

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14511

CERTIFICATE OF DEATH

14511

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		d. STREET ADDRESS 4806 Sheridan Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD Adams		4. DATE OF DEATH Month October 2 Year 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH 7-25-95	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTRUMENT WORKER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACOB ADAMS		14. MOTHER'S MAIDEN NAME ELIZABETH KEYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 039005A	
17. INFORMANT LUCY N. ADAMS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 400 ONSET BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Cardiac cirrhosis ONSET AND DEATH 15 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	
21. I certify that (I) (this hospital) attended the deceased from 1961 , 19, to 10-2- , 19, that (I) (we) last saw the deceased alive on October 2 1966 and that death occurred at 2:15 P.M. from causes and on the date stated above.		22. SIGNATURE Albert Roth	
22c. PHYSICIAN'S NAME (Type) ALBERT ROTH.		22d. ADDRESS RIVERDALE MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5 Oct. 1966.	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fort Lincoln Cemetery		23d. LOCATION (City or Town) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chamberlain Co. Riverdale, Md.		25a. REC'D BY REGISTRAR DATE OCT 5 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1127

1127

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14512 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14512

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton DOA		b. COUNTY	
c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlyne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Medical Center		d. STREET ADDRESS 155 Evergreen Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17-3	
3. NAME OF DECEASED (Type or print) Hattie Herma Allen		4. DATE OF DEATH 10	Month 10
5. SEX Female White		6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 13 Oct. 1899		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY CURTIS PUB. CO	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERT G ALLEN		14. MOTHER'S MAIDEN NAME ANNA M. FISCHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MISS GERTRUDE ALLEN		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5410 Gastric hemorrhage DUE TO Duodenal ulcer		INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-11-66	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Locustwood MEM PARK
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, MARYLAND		ADDRESS	23d. LOCATION (City, town or county) CHERRY Hill NEW JERSEY
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE j Charles Judge	DATE OCT 14 1966

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14513

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and then any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES , MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6811- RIGGS RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL MANOR		d. STREET ADDRESS HYATTSVILLE MD	
3. NAME OF DECEASED (Type or print) SARAH		First REBECCA	Middle ELLEN
4. DATE OF DEATH Month Oct Day 25 Year 1966		5. SEX F	6. COLOR OR RACE W
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 3, 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NORFOLK VA.		12. CITIZEN OF WHAT COUNTRY? HYATTSVILLE MD	
13. FATHER'S NAME GEORGE HOGWOOD		14. MOTHER'S MOTHER'S NAME SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. MRS Gladys L A Scoll A	
17. INFORMANT Address 6811-RIGGS RD. HYATTSVILLE MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic heart disease	
		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General arteriosclerosis - marked hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 909 Forsyth St. Dr. S. S. S. G. M.
20f. (City or town) HYATTSVILLE		(County) MARYLAND	
(State) MD		21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 59 to Oct 25, 1966 , that (I) (we) last saw the deceased alive on July 24, 1966 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED Oct 26, 1966	
22c. PHYSICIAN'S NAME (Type) Harry N. Carlton		22d. ADDRESS 909 Forsyth St. Dr. S. S. S. G. M.	22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL/CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial Oct 25, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL	23d. LOCATION (City, town or county) ARLINGTON VA.
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll NW-102		25a. ADDRESS 254 Carroll NW-102	25b. REC'D BY REGISTRAR DATE OCT 31 1966
		25c. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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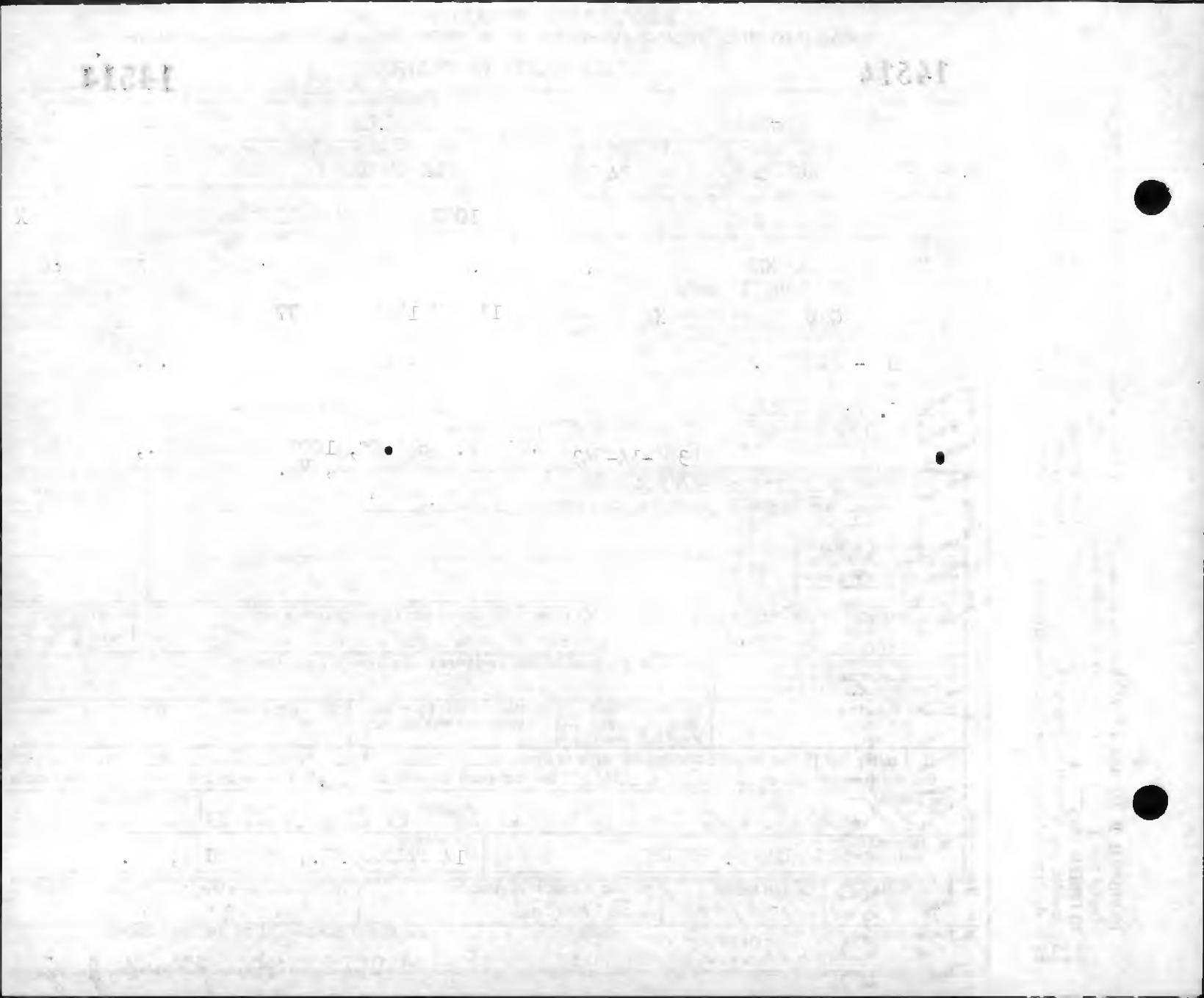
14514

CERTIFICATE OF DEATH

14514

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 16 24 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			d. STREET ADDRESS 1002 KENNEDY STREET		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First FRANCES Middle R. Last ASHLEY		4. DATE OF DEATH OCTOBER 22 1966		Month Day Year	
S. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11 NOV 1888	9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WISCONSIN
13. FATHER'S NAME LOUIS E. FREDERICKSON			14. MOTHER'S MAIDEN NAME HANSEN, Hansen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 388-14-8438		17. INFORMANT John F. Rohlloff, 1002 KENNEDY ST., FALLS CHURCH, VA.	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> DUE TO <u>465X</u> Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause (c) _____ DUE TO _____ last. _____					
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Chronic congestive heart failure of unknown cause</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6 May, 1966</u> to <u>22 Oct, 1966</u> , that (I) (we) last saw the deceased alive on <u>22 Oct 1966</u> , and that death occurred at <u>914 Palmer Rd.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Charles D. Phelps</u>		22b. DATE SIGNED 22 Oct 66			
22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS		22d. ADDRESS 914 PALMER RD., OXON HILL, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/26/66		23c. NAME OF CEMETERY OR CREMATORIUM Elmwood	
24. FUNERAL DIRECTOR W.W. Chambers & Inc.		ADDRESS 1400 Chapin St. N.W. Wash., D.C.		25a. RECD BY REGISTRAR DATE: OCT 26 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles D. Phelps</u>					



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14515 14515

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
Prince George's MARYLAND		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3232 Chillum Road, Apt. 201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha		First Louise	Middle Baker
4. DATE OF DEATH 10 17 19 66		5. SEX Female	6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9 May 1907	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME KARL G. XANDER	
14. MOTHER'S MAIDEN NAME ANNA M. HARR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT CLARA C. FRAZIER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head		Address 3343 BUCHANAN ST. MT. RAINIER, MD	
976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self at home.	
20c. TIME OF INJURY Month, Day, Year about 1:00 a.m. 10-17 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedroom of home
20f. (City or town) same as #2		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED 10-18-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) CREMATION		23b. DATE THEREOF Oct 18, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS FORT LINCOLN CREMATORIAL		23d. LOCATION (City, town or county) BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		25a. RECD BY REGISTRAR DCT 19 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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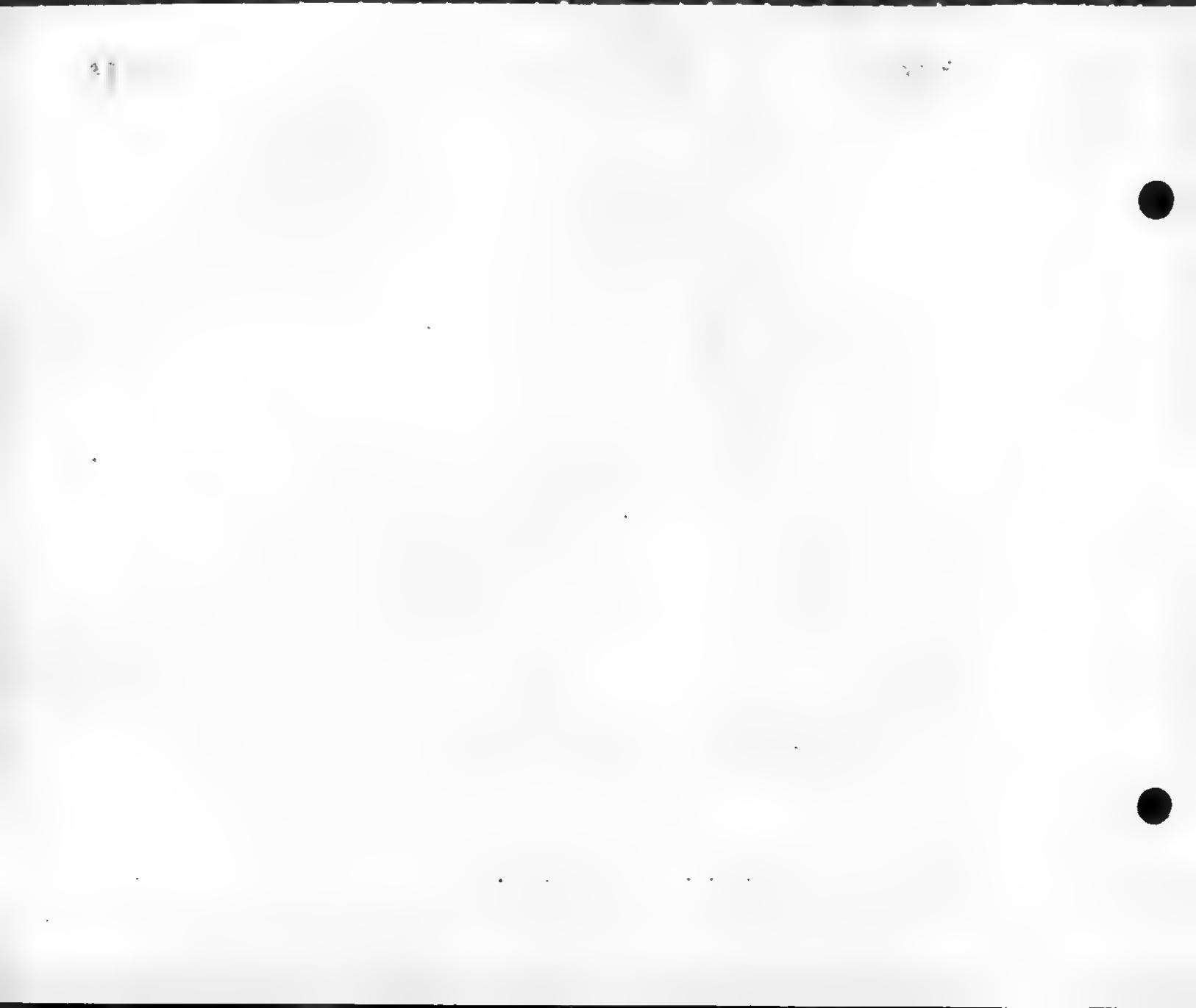
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 7 Film G352 11/15/66 mn

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14516

14516

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb 55 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mayme		First	Middle
		Last	
4 DATE OF DEATH 10 31 1966		Month	Day Year
S. SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11b KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME William Trammell		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16 SOCIAL SECURITY NO 577 48 7378	17 INFORMANT Harry A Miller
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. AGE (In years lost birthday) 71 yrs	
9 40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
DUE TO Multiple pulmonary emboli		INTERVAL BETWEEN ONSET AND DEATH 55 days	
(b) DUE TO Generalized arteriosclerosis			
(c) DUE TO From Phlebo thrombosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home	
20c TIME OF INJURY Month, Day, Year about 9:00 a.m. 9-6- 1966		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home
20f. (City or town) same as #2		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Colmar Manor Pro Geo Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov 4, 1966	23c NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery
23d LOCATION (City or Town) Colmar Manor Pro Geo		(County) (State)	
24 FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a REC'D BY REGISTRAR DATE NOV 7 1966
			25b REGISTRAR'S SIGNATURE Charles Judd



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14517

1. PLACE OF DEATH

COUNTY

PRINCE GEORGES

MARYLAND

B. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HYATTSVILLE

C. LENGTH OF STAY IN 1b

37 days

4. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HYATTSVILLE NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years) UNDER 1 YEAR UNDER 24 HRS.

last birthday

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

- - -

13. FATHER'S NAME

James J. Holzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) IF yes give war or dates of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

577-10-8788 Ernest Goodwin 3205 Rittenhouse St NW

Address

WIEKORN

14. MOTHER'S MAIDEN NAME

Ida Alvina Holzer

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
3 months

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

OUE TO
(b)
OUE TO
(c)

General arterio sclerosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) attended the deceased from July 15, 1966, to Oct 13, 1966, that (I) last saw the deceased alive on Oct 6, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

LW Malar

22b. DATE SIGNED

10-13-66

22c. PHYSICIAN'S
NAME (Type)

LW Malar M.D. Keweenaw, MI

M.D. ATTENDING PHYS.

M.D. STAFF PHYS.

M.D. STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 10-17-66

23b. DATE THEREOF

Prospect Hill Cemetery

23d. LOCATION (City, town or county) (State)

WASHINGTON, D.C.

24. FUNERAL DIRECTOR

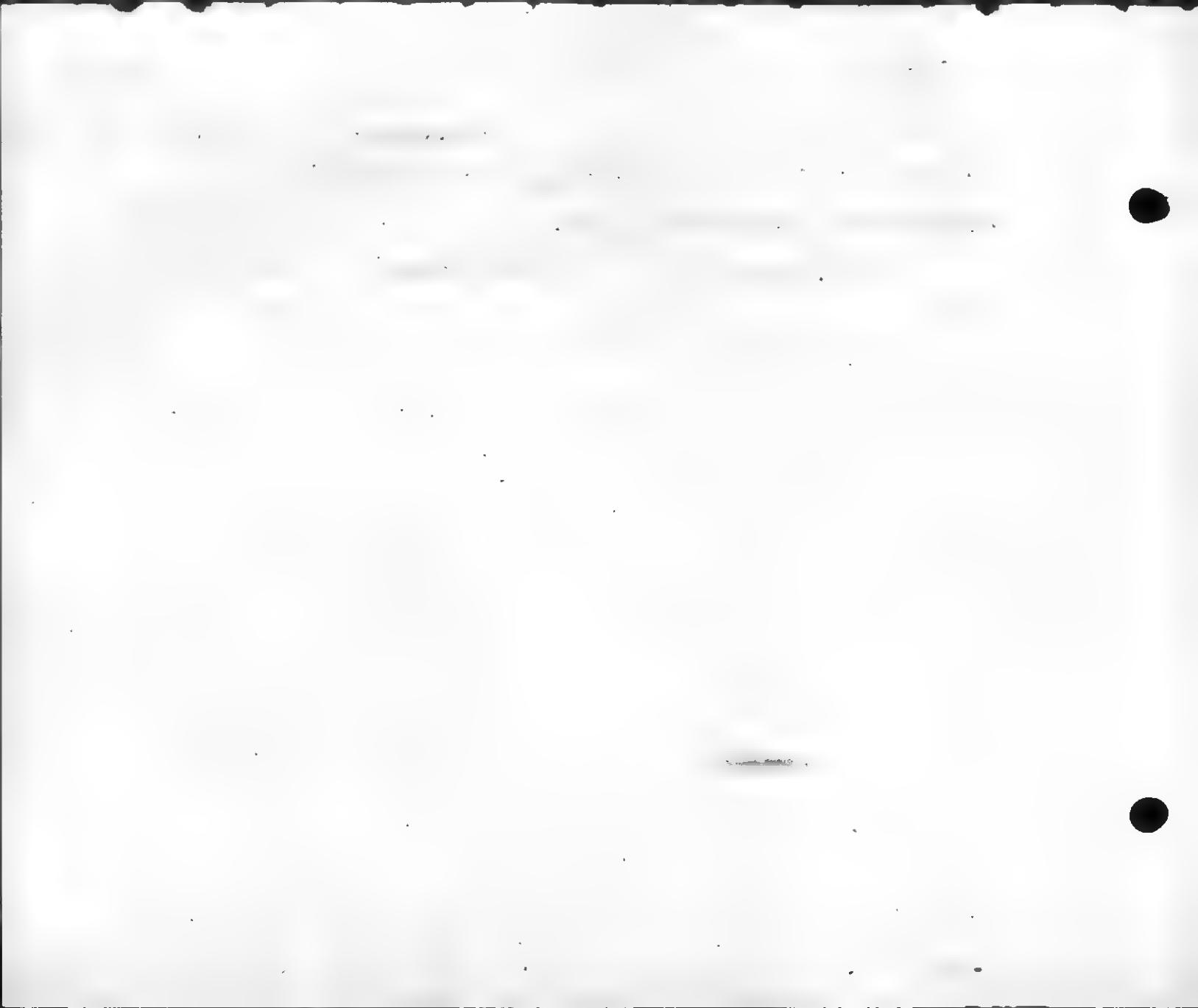
ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Charles Judge

DATE OCT 19 1966

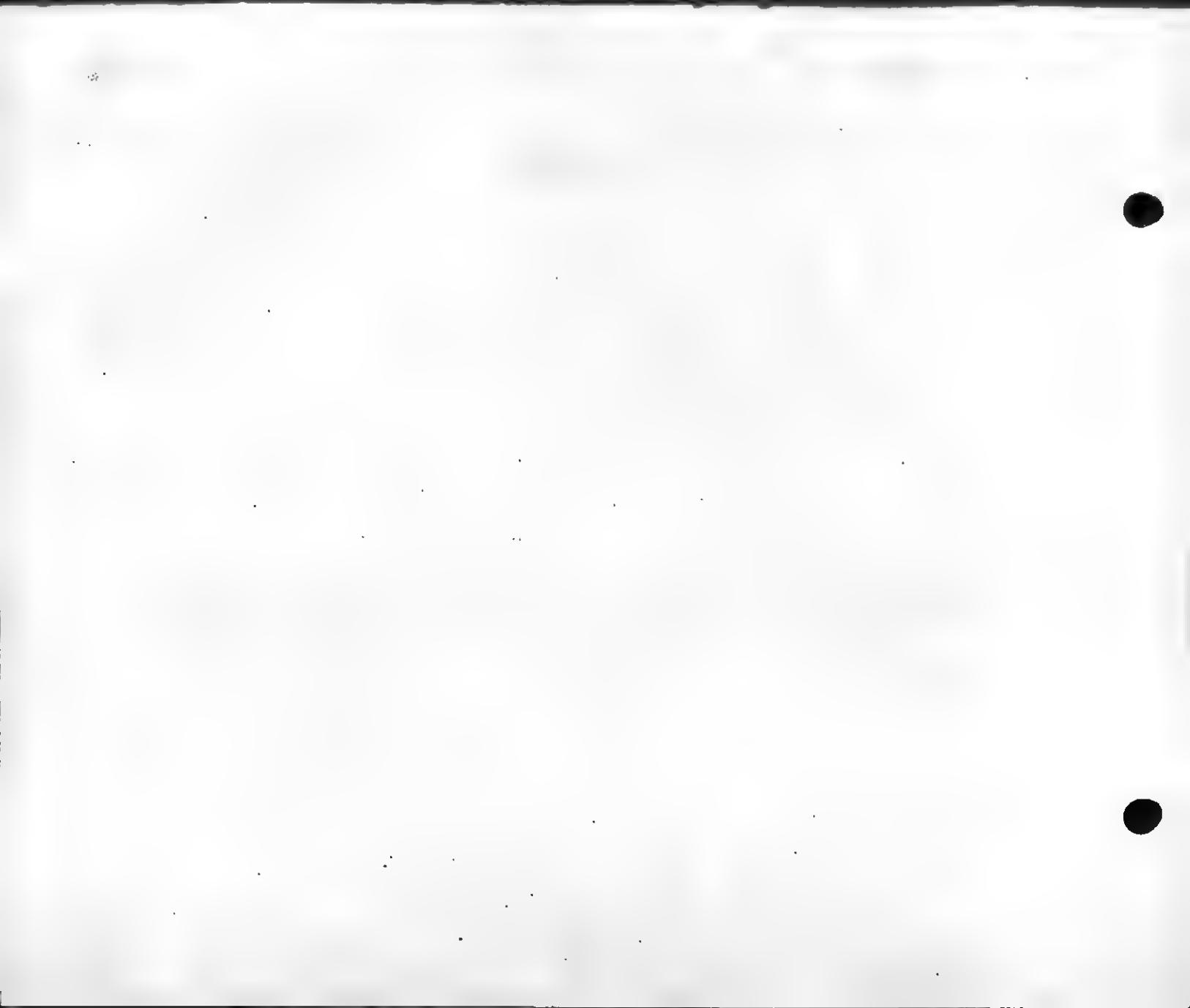


1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trait permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14513 CERTIFICATE OF DEATH Items 1c, 2, 10b, 21, 24, Film 74302 1/7/66 mh 14518											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville											
c. LENGTH OF STAY IN MD 25 days											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hyattsville Nurs' Home											
e. NAME OF DECEASED First MIDDLE Last 4. DATE OF DEATH Month Day Year (Type or print) OSCAR LEVI Bancroft 10 10 28 1966											
5. SEX m 6. COLOR OR RACE w 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (in years last birthday) 10. IF UNDER 1 YEAR IF UNDER 24 HRS. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Government Clerk, Federal Government											
11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Spink Co. South Dakota, yes usa											
13. FATHER'S NAME Lorey Jerome 14. MOTHER'S MAIDEN NAME John Bancroft - Rozelen Jane Morse											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) No - 578-32-2313 daughter - Mrs. Walter B. W. Highsmith											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA; RESPIRATORY ARREST DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) SEVERE GENERALIZED ATHEROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 48 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 13 DAYS YEARS.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CDNTR BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 19											
21. I certify that (I) (this hospital) attended the deceased from 5/30 1966, to 10/28 1966, that (I) (we) last saw the deceased alive on 10/27 1966, and that death occurred at 12:22 M, from the causes and on the date stated above.											
22a. SIGNATURE Harold W. Draper 22b. DATE SIGNED 10/28/66											
22c. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D. 22d. ADDRESS 911 SILVER SPRING AVE; SILVER SPRING											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL (State) Burial Oct 31, 1966 George Washington											
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur Coffers 294 Speer St. NW OCT 31 1966											
25c. DATE											



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14519 14519

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Prince</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenn Dale</i>		b. COUNTY <i>Rural</i>	
c. LENGTH OF STAY IN 1b <i>Summer</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Montgomery</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home Inc.</i>		d. STREET ADDRESS <i>2407 Bonniville Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>THOMAS GILBERT BARKUS</i>		First	Middle
4. DATE OF DEATH <i>Oct 2 1966</i>		Last	Month
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct 19 1916</i>		9. AGE (In years last birthday) <i>49 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Milkman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Montgomery, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Montgomery, Maryland</i>	
13. FATHER'S NAME <i>JAMES EDGAR BARKUS</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA N. TAYLOR</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>476-50-1234</i>	
17. INFORMANT <i>Robert J. Muller, Son</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart disease</i>	
DUE TO (b) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
DUE TO (c) <i>Myocardial fibrosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home Inc.</i>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dayon C. Watkins</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>DAYON C. WATKINS</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>10-3-66</i>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10/7/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>New Alexandria Cem. Mt Rainier, Maryland</i>
23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14520

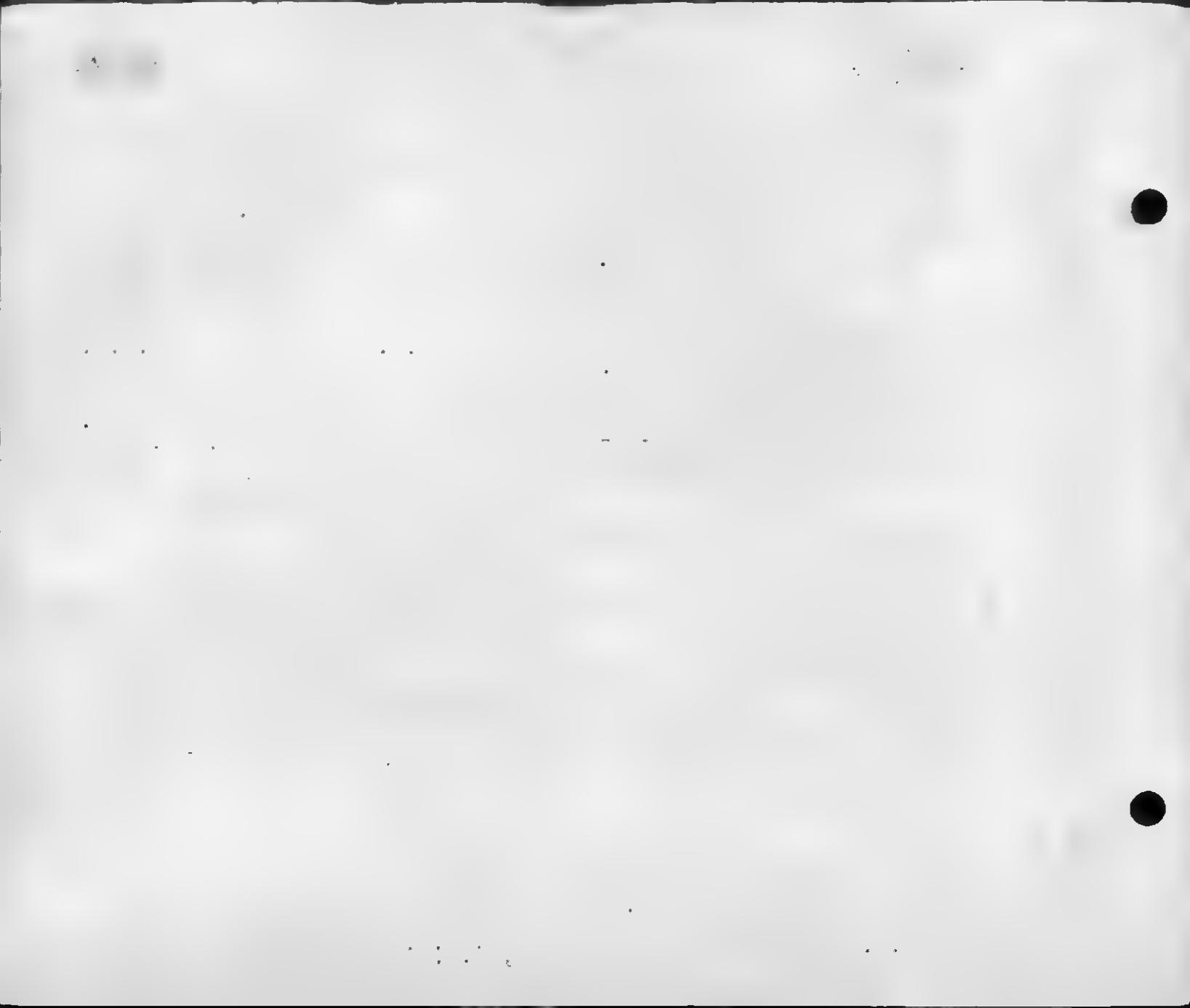
CERTIFICATE OF DEATH

14520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove, sign on papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		b. COUNTY Prince Georges	
c. LENGTH OF STAY IN 1b 8861 River View Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 8861 River View Rd.	
3. NAME OF DECEASED (Type or print) Henry A. Bartholomew		4. DATE OF DEATH October 12 1966	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/8/82	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDERT 1 YEAR Months Days	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of Continental Life Insurance N.C.		11. KIND OF BUSINESS OR INDUSTRY Co.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Augustus Bartholomew	
14. MOTHER'S MAIDEN NAME Lucy Mitchell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 577-10-5779		17. INFORMANT Vernon Cox	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH 9/1-66 1945	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Cardiac Failure, pulmonary edema Pernicious Anemia. pneumonit.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1935 to 10-12-66, that (I) (we) last saw the deceased alive on 10-12-66, and that death occurred at 11:45 A.M. on the causes and on the date stated above			
22e. SIGNATURE Frederick A. Reuter		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) 2520 L ST NW		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23e. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/14/66	
23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		25a. ADDRESS 2901 14th St. N.W. Washington, D.C.	
		25b. REC'D BY REGISTRAR DATE OCT 17 1966	
		25c. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14521

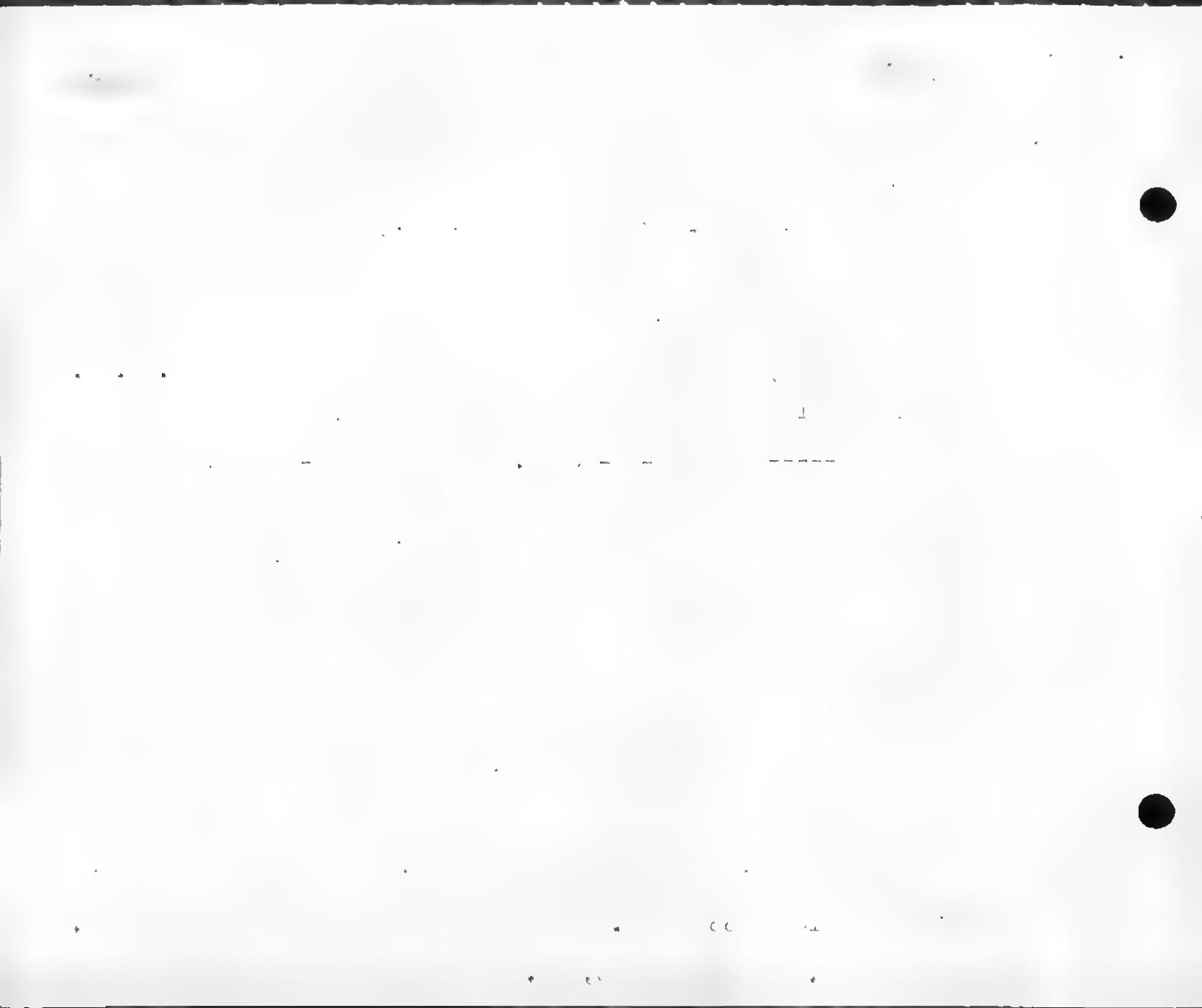
CERTIFICATE OF DEATH

14521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor		d. STREET ADDRESS RFD Bx. 3569	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Oden	Middle Lee	Last Beall	4 DATE OF DEATH October 13 19 66	Month October	Day 13	Year 19 66
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/27/80	9 AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clinton Beall		14. MOTHER'S MAIDEN NAME Mary Stockett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-46-7025		17. INFORMANT J. Francis Beall-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary</u>						INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arterosclerotic CVR disease</u>		DUE TO (b) <u>Arterosclerotic CVR disease</u>				DUE TO (c) <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> to <u>13 Oct 66</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>13 Oct 66</u> and that death occurred at <u>8:40 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>RB Janer</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert B. G. Sasscer		22d. ADDRESS RFD Bx. 2150, Upper Marlboro, Md.		22e. DATE SIGNED 10-14-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Upper Marlboro Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE OCT 25 1966 g Charles Judge	



FOR STATE
HEALTH DEPT.

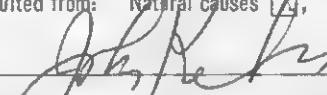
14522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14522

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return them within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
Prince George's Maryland		Maryland Prince George's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1D DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Hyattsville 1400 Jefferson Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Lemuel	Last Beaton
4. DATE OF DEATH	10	Month	Day 12
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 April 1914
9. AGE (in years last birthday) 52 yrs.	10. IF UNDERTAKER 11. BIRTHPLACE (State or foreign country) North Dakota	12. IF UNDERTAKER 24 HRS. Months Days Hours Min. U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - G.A.O.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
13. FATHER'S NAME John P. Beaton		14. MOTHER'S MAIDEN NAME Malloy F. Tally	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-40-6191 17. INFORMANT Mrs. Edna L. Beaton (above address) (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Bilateral		INTERVAL BETWEEN ONSET AND DEATH	
1220 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) Acute Intoxication Ethyl Alcohol (0.316)	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-13-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery
23d. LOCATION (City, town or county) Wash., D.C.		(State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. ADDRESS Mt. Rainier Maryland	
25b. REC'D BY REGISTRAR OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14523

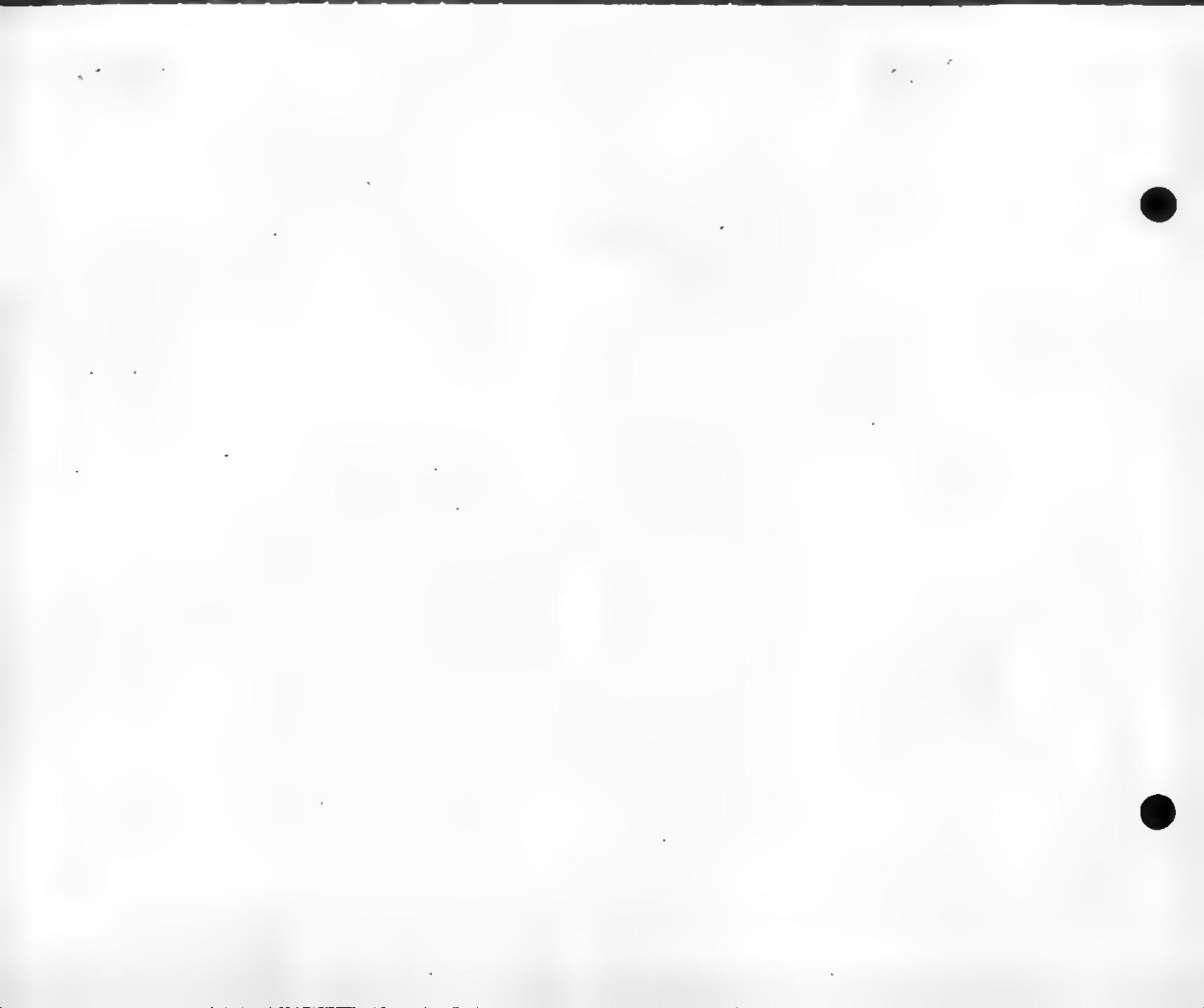
CERTIFICATE OF DEATH

14523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 4001 38th St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Julia	Elizabeth		Beckdahl	October	29,	19	66
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH 9/22/86	10. AGE (In years last birthday) 80 yrs	11. IF UNDER 1 YEAR Months	12. IF UNDER 24 HRS. Days Hours Min.
Female	White						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Ralph B. Wyrick				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Carl F. Beckuahl		Address 4001 38th St. Brentwood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) f x u o Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO (d) ASHD							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 1963, to October 29, 1966, that (I) (we) last saw the deceased alive on October 29, 1966, and that death occurred at 10:45M, from causes and on the date stated above.							
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED 10-30-66					
22c. PHYSICIAN'S NAME (Type) BENJAMIN S. MILLER		22d. ADDRESS Prince George County Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-2-66		23c. NAME OF CEMETERY OR CREMATORIAL Washington National		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR W.W. Chambers		ADDRESS Co. Riverdale, Md.		25a. REC'D BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14524

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale		d. STREET ADDRESS Brooklyn Road		16.1	
3. NAME OF DECEASED (Type or print) Charles		First Middle		Lost Bell		4. DATE OF DEATH October 27 1966		Month Doy Year	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED WIDOWED		8. DATE OF BIRTH Apr 21 1931		9. AGE (In years lost birthday) 35 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lambeth Rd		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Webster Bell		14. MOTHER'S MAIDEN NAME Elizabeth Payton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Raymond Bell Same as 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 45.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19. INTERVAL BETWEEN ONSET AND DEATH Gudiae tamponade		20. DUE TO (b) Diseasing Anerysm, Aorta with (c) intra pericardial tear					
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) Arlington		(County) Md.	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 25, 1966, to Oct. 27, 1966, that <input type="checkbox"/> (we) last saw the deceased alive on October 27, 1966, and that death occurred at 1:00 P.M. from causes and on the date stated above.		22b. DATE SIGNED 10-28-66							
22a. SIGNATURE Roger B. Ingham, M.D.		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> B.M. PHYS. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22d. ADDRESS 5701 85th Ave. Carrollton, Md.		23a. MEDICAL CERTIFICATION							
23b. DATE THEREOF 11-1-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat		23d. LOCATION (City or Town) Arlington VA					
24. FUNERAL DIRECTOR H. S. Washington & Sons 4925 Penn Ave 20 M 1/66		25a. ADDRESS H. S. Washington & Sons 4925 Penn Ave 25b. REGISTRAR'S SIGNATURE Charles Judge							
25c. REC'D BY REGISTRAR DATE NOV 3 1966									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14525

CERTIFICATE OF DEATH

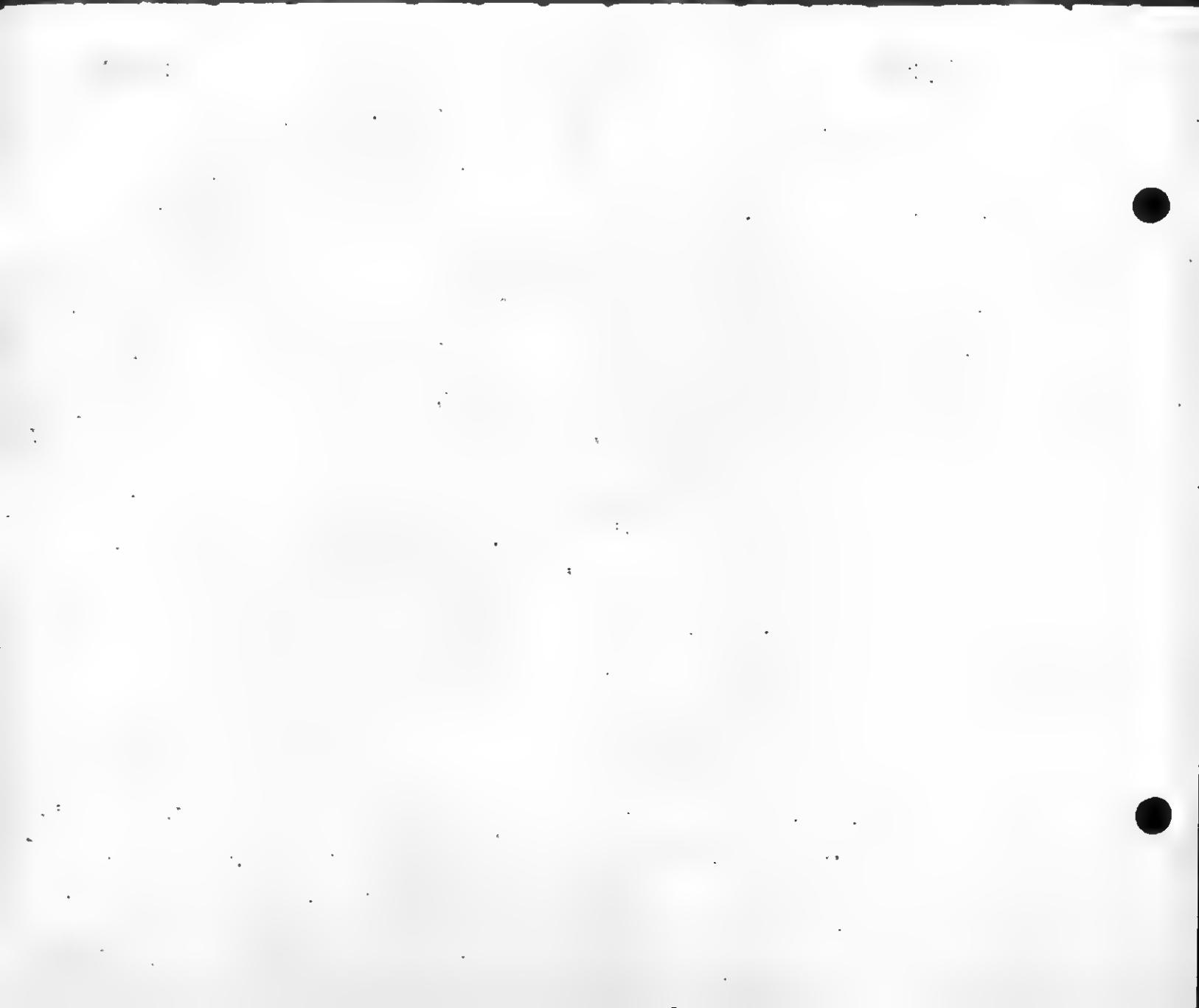
14525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH COUNTRY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Riverdale	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland RIVERDALE	
c. LENGTH OF STAY IN 1D MARYLAND		d. STREET ADDRESS 5903 Harrison AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LELAND MEM HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First OSCAR	Middle W. BENKERT.	Last 4. DATE OF DEATH Oct 31 1966
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 JULY 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER + DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY DECORATING	
13. FATHER'S NAME JOHANN BENKERT		11. BIRTHPLACE (County & State, or foreign country) GERMANY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577 03 7978A	
17. INFORMANT MISS EDITH A. BENKERT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myocardial Infarction</i> <i>Coronary Thrombosis</i> <i>Atherosclerotic Heart Disease</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hyattsville (County) Maryland (State) MD		21. I certify that (I) (this hospital) attended the deceased from 1966 to 10-31 1966 , that (I) (we) last saw the deceased alive on 10-16 1966 , and that death occurred at 3 P.M. from the causes and on the date stated above.	
22a. SIGNATURE <i>Donald C. Edgren</i>		22b. DATE SIGNED 11-1-1966	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22d. ADDRESS HYATTSVILLE, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4 Nov 1966	23c. NAME OF CEMETERY OR CREMATORIAL GEORGE WASHINGTON MEM PH
24. FUNERAL DIRECTOR W. W. Chambers Co., Riverdale, Md.		25a. ADDRESS W. W. Chambers Co., Riverdale, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge
25c. DATE NOV 3 1966		25d. LOCATION (City, town or county) HYATTSVILLE, MARYLAND	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

14526

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. That page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK		First - Middle - Last Berlin	4. DATE OF DEATH 10 Month 2 Year 1966
5. SEX Male	6. COLOR OR RACE cauc	7. MARRIED WIDOWED	8. DATE OF BIRTH Dec 15, 1883
9. AGE (in years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Tallow (Cet.) Chaffing		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Moishe Berlin		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO 064-01-7380	
17. INFORMANT Rose Berlin - Son # 2.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 13 pneumococcal pneumonia left lower lobe 2 weeks	
(b) DUE TO Hypertensive cardiovascular disease		15 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(d) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/19/66 to 10/12/66 that (I) (we) last saw the deceased alive on 10/11/1966, and that death occurred at H.A. M., from causes and on the date stated above.		22b. DATE SIGNED 10-2-66	
22a. SIGNATURE Peter D. Dicus		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Peter Dicus		22d. ADDRESS 6124 Central Ave. Cap Hts. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/3/66	23c. NAME OF CEMETERY OR CREMATORIAL BETH ISRAEL
23d. LOCATION (City or Town) Woodbridge, N.J.		(County) (State)	
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217-92th N.W.		25a. REC'D BY REGISTRAR DCT 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14527 14527

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale DCA		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b DCA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis A.		First	Middle
4. DATE OF DEATH Bickling Jr. 10		Last	Month
5. SEX M W		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Lewis A. Bickling Sr.		14. MOTHER'S MAIDEN NAME Dorothy Kauffroth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Dorothy Botaorf.		Address 38 Ridge Ave. Phoenixville, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain		INTERVAL BETWEEN ONSET AND DEATH Minutes	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma-auto accident			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Driver of motorcycle hit from behind by auto	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:25 p.m. 10-3-66		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) University Blvd.
20f. (City or town) P.G.		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		22. DATE SIGNED 10-30-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-2-66	23c. NAME OF CEMETERY OR CREMATORIUM Morris Cemetery
24. FUNERAL DIRECTOR W. W. Chambers Co. Inc. Riverdale, Md.		23d. LOCATION (City, town or county) Phoenixville, Pa. (State)	
ADDRESS		25a. REC'D BY REGISTRAR NOV 2 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 film G382 11/4/66 mh

14528

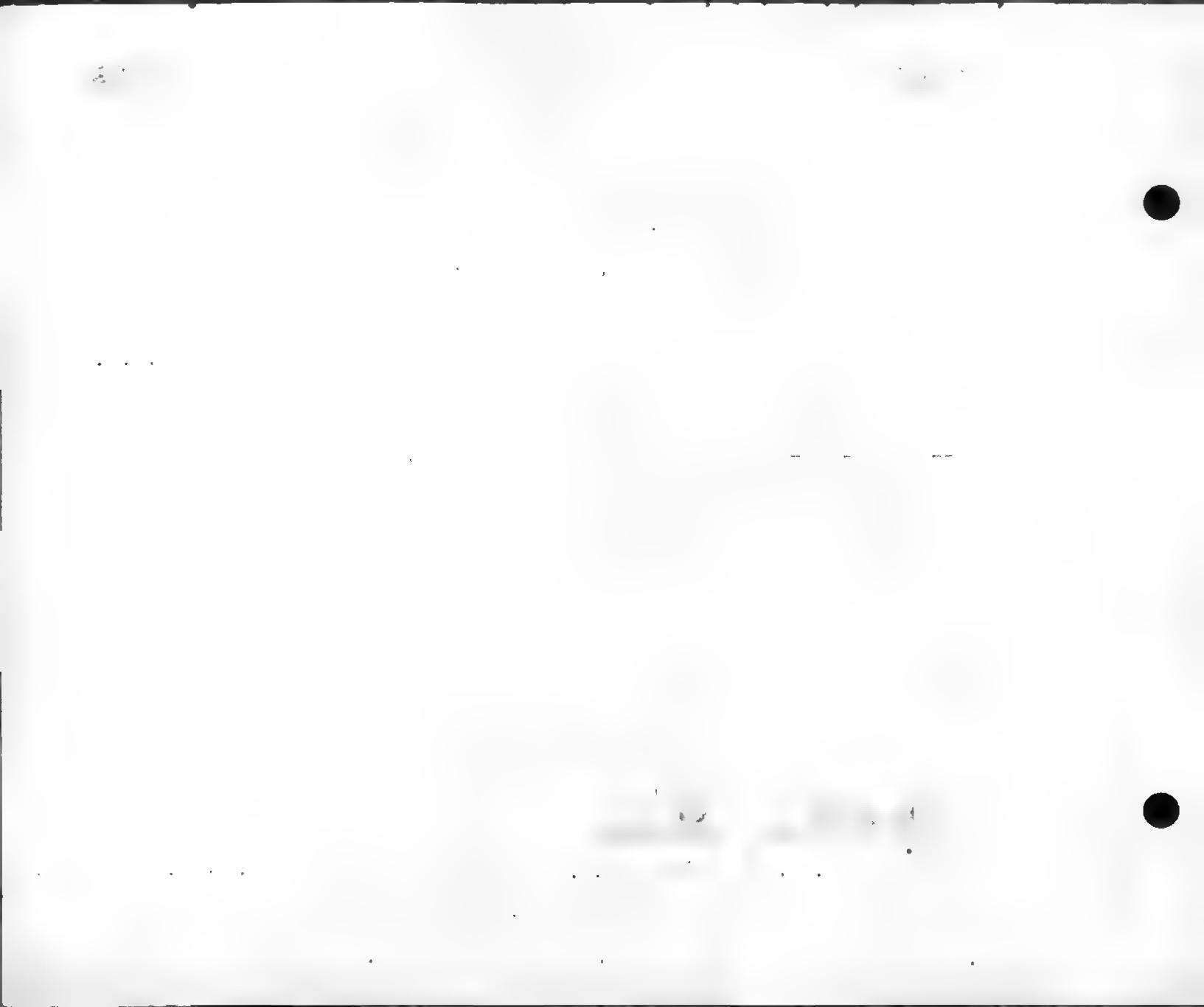
CERTIFICATE OF DEATH

14528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE New York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY ✓ Bronx	
c LENGTH OF STAY IN lb 5 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 870 Rosendale Avenue	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Nora	Middle F.	4. DATE OF DEATH October 16 1966
5 SEX Female	6. COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 June 1, 1892
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) House wife		9 AGE (In years last birthday) 71 72 yrs	
10b KIND OF BUSINESS OR INDUSTRY CIV. Home		11 BIRTHPLACE (County & State, or foreign country) New York	
13 FATHER'S NAME Jermiah Mullins		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO 063-20-5945	
17 INFORMANT Ernest F. Bajesse (Same as # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Paroxysmal</i> DUE TO <i>Cyanosis</i> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) <i>Cyanosis</i> DUE TO <i>of buccal mucosa</i> stating the underlying cause (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 11, 1966, to October 16, 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 16, 1966, and that death occurred at 9:35PM, from causes and on the date stated above.			
22a. SIGNATURE <i>M. P. Diaz-Giorle</i>		22b. DATE SIGNED 10-17-66	
22c. PHYSICIAN'S NAME (Type) M. P. Diaz-Giorle, M.D.		22d. ADDRESS Prince George's Genl. Hosp., Cheverly, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/20/66	
23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) New York, New York	
24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave., Hyattsville, Md.		25a. RFC'D BY REGISTRAR OCT 19 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE			



FOR STATE
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

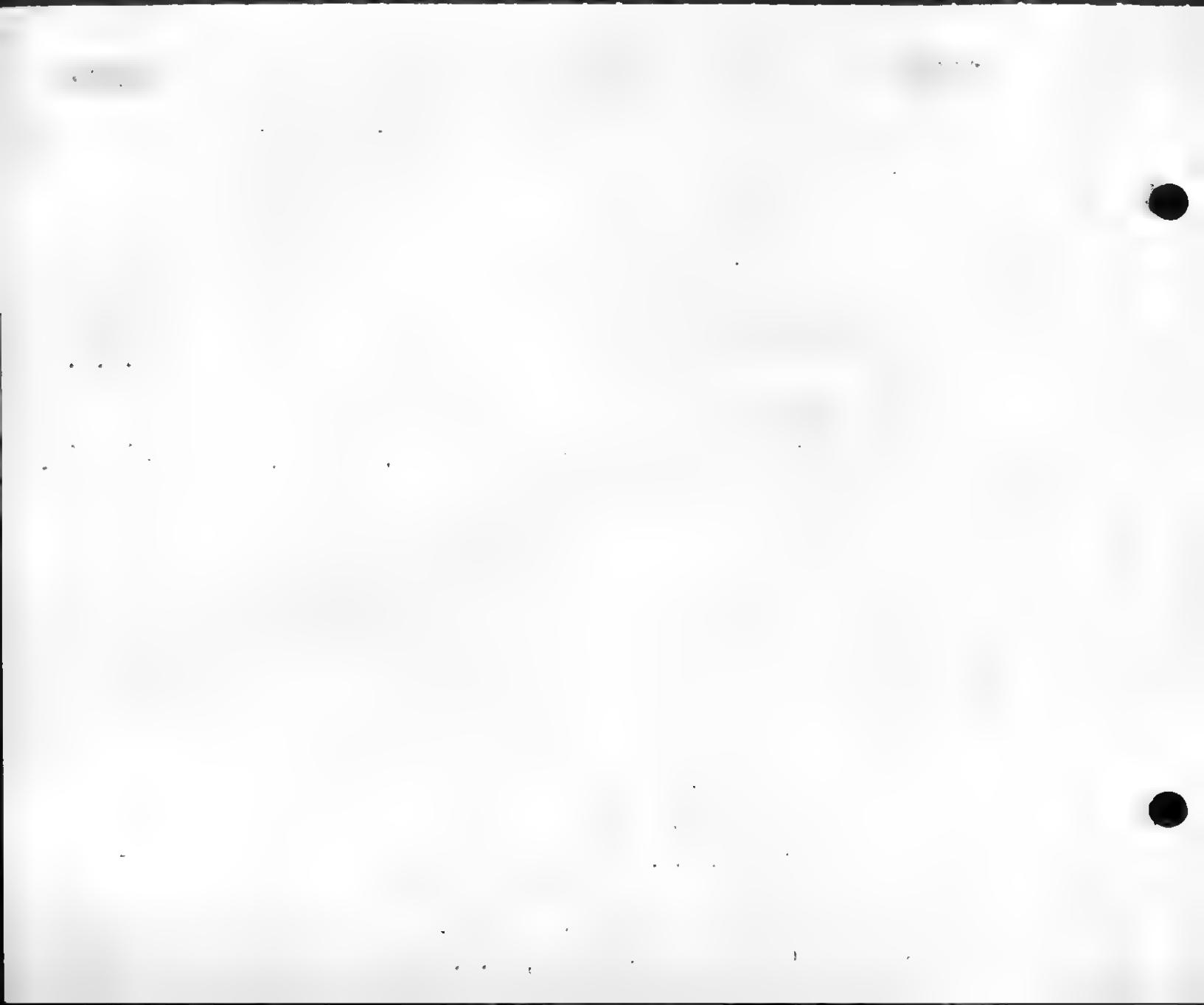
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14529 **14529**

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Md. b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Eagle-Bozman		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
	Randolph	Garland	Bishop	10	15 19 66
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
M	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 21, 1899	66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY N/A		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Westley Graham Bishop			14. MOTHER'S MAIDEN NAME Annie Frances Loane		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes W W I			16. SOCIAL SECURITY NO. 17. INFORMANT 579-44-4870 Randolph B. Bishop, 9408 Seddon Dr., Bethesda, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease			Address Minutes		
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease			Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10-15-66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/18/66			23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greenmount Cem.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.			23d. LOCATION (City, town or county) (State) Baltimore Maryland 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE OCT 19 1966 Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14531

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and file any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE b. COUNTY				
Prince Georges Maryland		Md Prince				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1129 - 65 ave				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General		d. STREET ADDRESS 1129 - 65 ave				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle			
4. DATE OF DEATH		Last	Month			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years) IF UNDER 1 YEAR last birthday	10. IF UNDER 24 HRS. Months Days Hours Min.
M		C		Nov. 6 1928 35	yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer		Construction		Lisville S.C.		USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Warren Block		Ella Ann Morris				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes us army		16. SOCIAL SECURITY NO.		17. INFORMANT		
				6408- Warren Block		Address Cedar Heights Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		20. DUE TO				
181A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Laceration of Right iliofemoral DUE TO				
		(c) Gun shot wound, abdomen				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. 10-5-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	20f. (City or town) Cedar Heights	(County) Md	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE DAYTON O WATKINS		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 10-6-66				
EXAMINER'S NAME (Type) DAYTON O WATKINS		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5318 Annapolis DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bladensburg Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-66	23c. NAME OF CEMETERY OR CREMATORIAL Harmony	23d. LOCATION (City, town or county) Lanham, Md.		
24. FUNERAL DIRECTOR Rollins Funeral Home		25a. ADDRESS 4339 Hunt Pl., N.E. 241 - Kershaw	25b. REC'D BY REGISTRAR DATE OCT 11 1966		25c. REGISTRAR'S SIGNATURE Charles Judge	



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necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

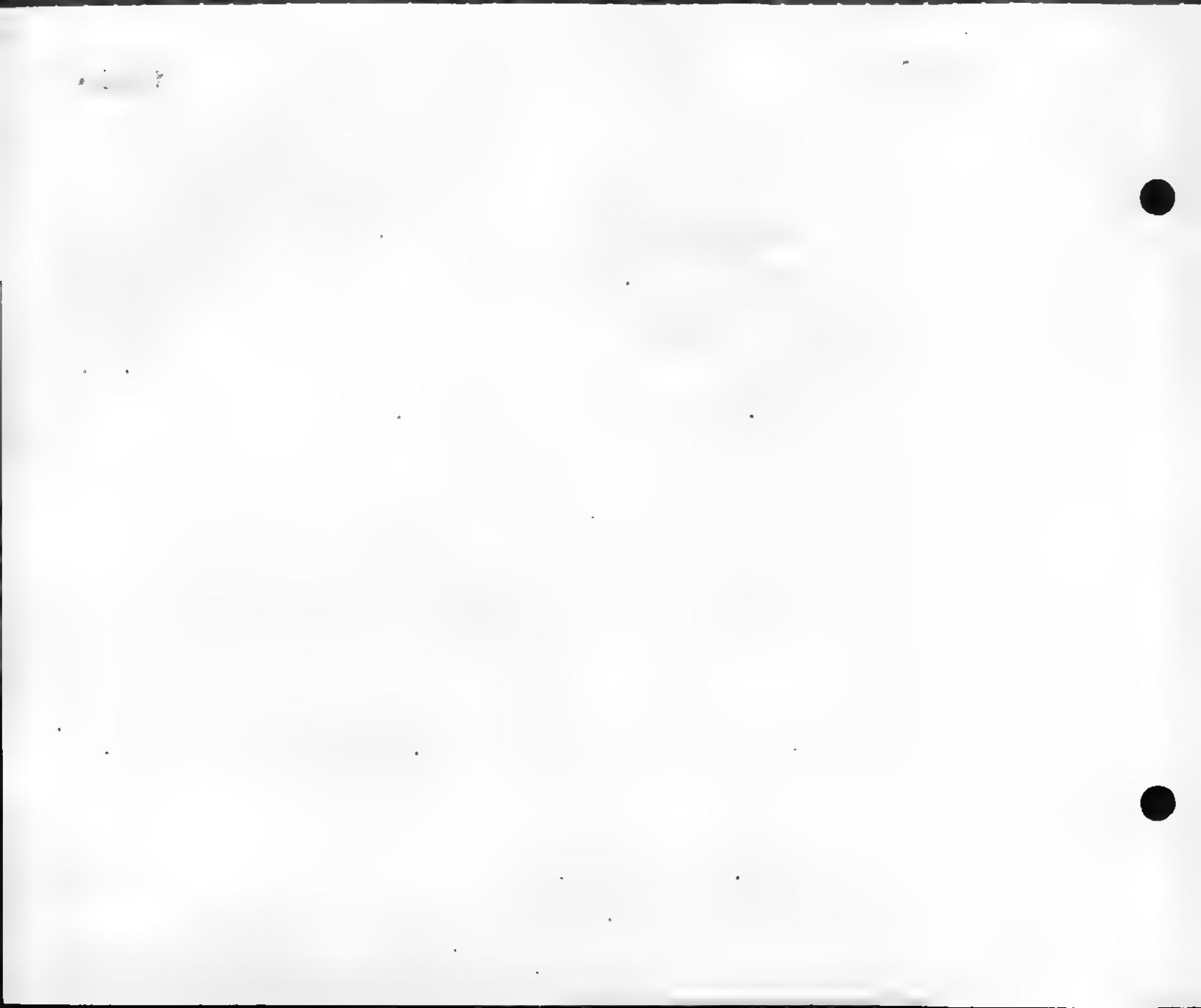
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14531

1 PLACE OF DEATH D. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3616 39th Avenue	
3 NAME OF DECEASED (Type or print) Bernard B. Blandford		4 DATE OF DEATH 10 '31 1966	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 20 March 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas S. Blandford		14. MOTHER'S MAIDEN NAME Emma T. Carroll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Edna Blandford 2415 Colebrooke Drive		Address Hillcrest Hgts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemothorax, right side DUE TO and hemoperitoneum Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) From lacerations of right lower lung and liver DUE TO From multiple gun shot wounds (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot by assailants	
20c. TIME OF INJURY Month, Day, Year About hour on 1:00 a.m. 10-31-1966		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Lottsford Rd., 2 miles off Landover Rd.
20f. (City or town) (County) (State) Prince George County, Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 10-31-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-3-1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's	
23d. LOCATION (City or Town) Piscataway, Md		(County) (State)	
24. FUNERAL DIRECTOR <i>Robert M. Mattingly</i>		25a. REC'D BY REGISTRAR DATE NOV 3 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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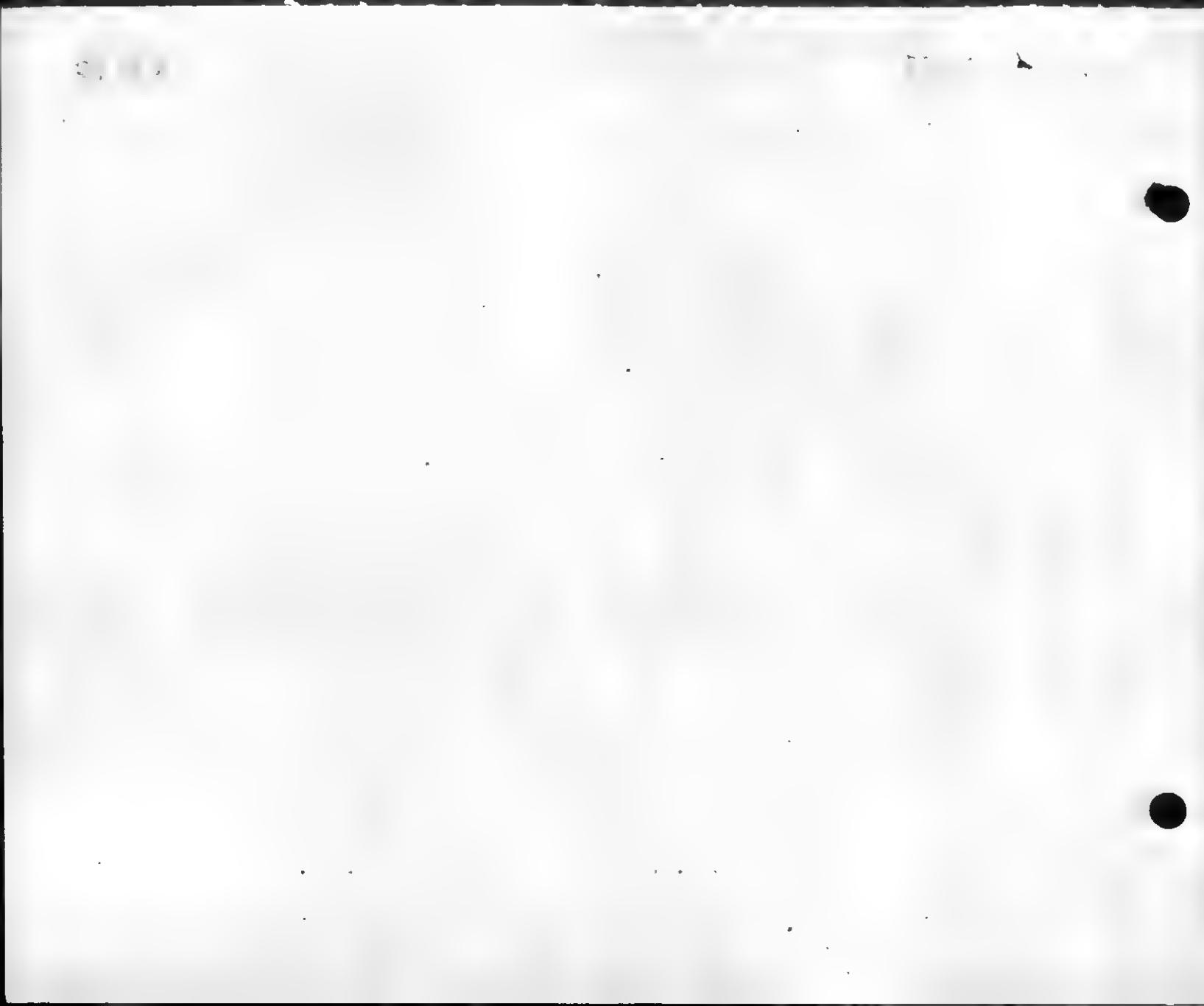
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14532

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. LENGTH OF STAY IN 1b Forest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 332 Cree Drive		d. STREET ADDRESS 332 Cree Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas J. Blohm		First	Middle
4. DATE OF DEATH October 7 1966		Last	Month Day Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-8-13		9. AGE (In years last birthday) 33 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property Manager—Weavers Bros.		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Blohm		14. MOTHER'S MAIDEN NAME Mary Flanigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-10-9167 17. INFORMANT Mildred L. Blohm Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 716 X		INTERVAL BETWEEN ONSET AND DEATH minutes	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with shotgun	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 Noon p.m. 10-7-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Riverdale, Md. (County) Baltimore (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 10-1966 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill Cemetery 23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE	
Simmons Bros. 1601-Good Hope Rd SE Wash DC		DATE OCT 11 1966	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, to be retained for your files.

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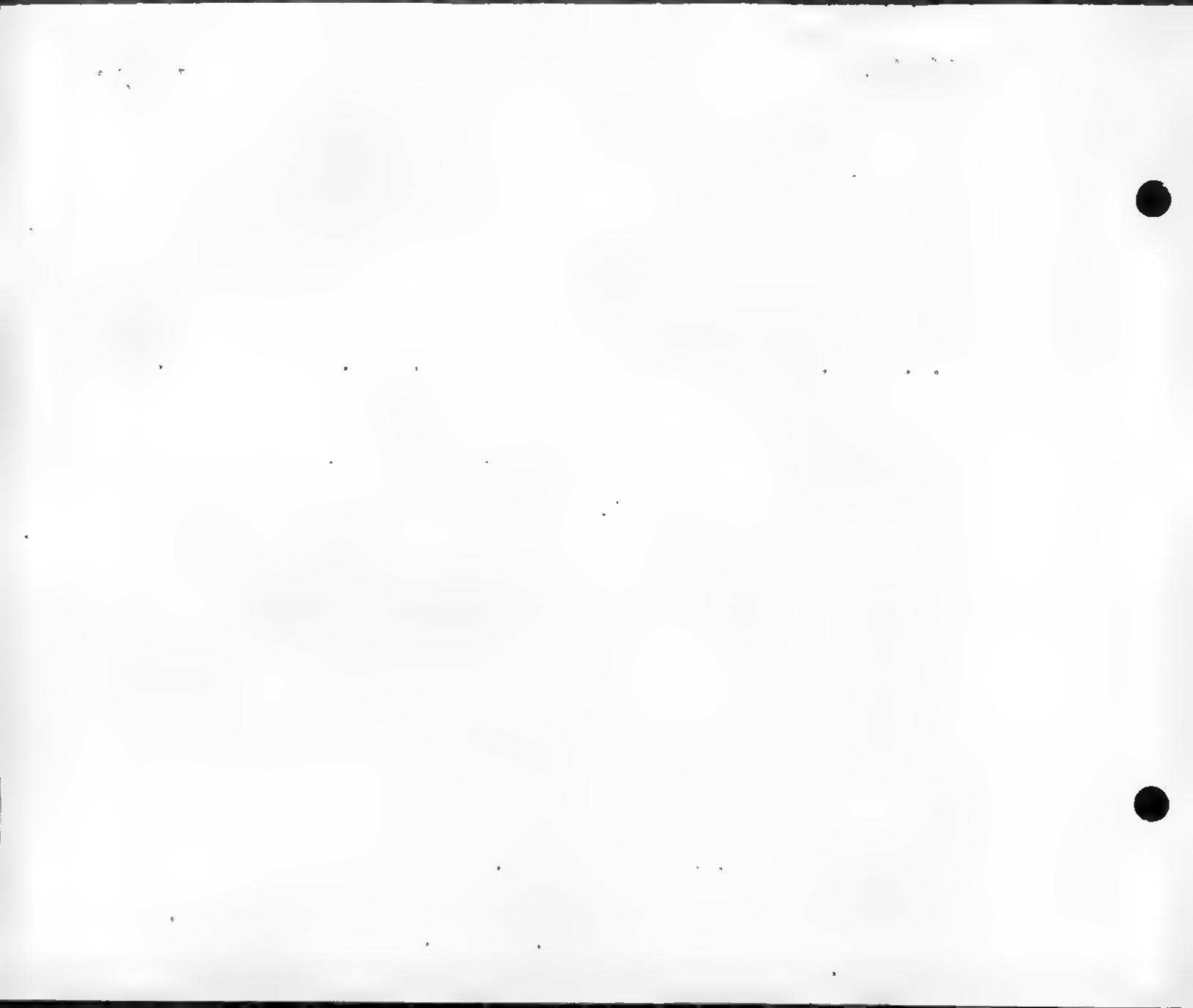
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14533

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 223 Maryland Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Lewis	4. DATE OF DEATH Month 10 Day 25 Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED W. DIVORCED <input checked="" type="checkbox"/>	8. NEVER MARRIED D. DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
13. FATHER'S NAME Jack Brightley		14. MOTHER'S MAIDEN NAME Rose Heck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Margaret L. Brightley (above address) (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Due to Hypertensive arteriosclerotic heart disease over 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 10-26-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/28/66	
23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Md.	
24. FUNERAL DIRECTOR Malley's Funeral Home Inc.		25a. RECEIVED BY REGISTRAR DATE OCT 31 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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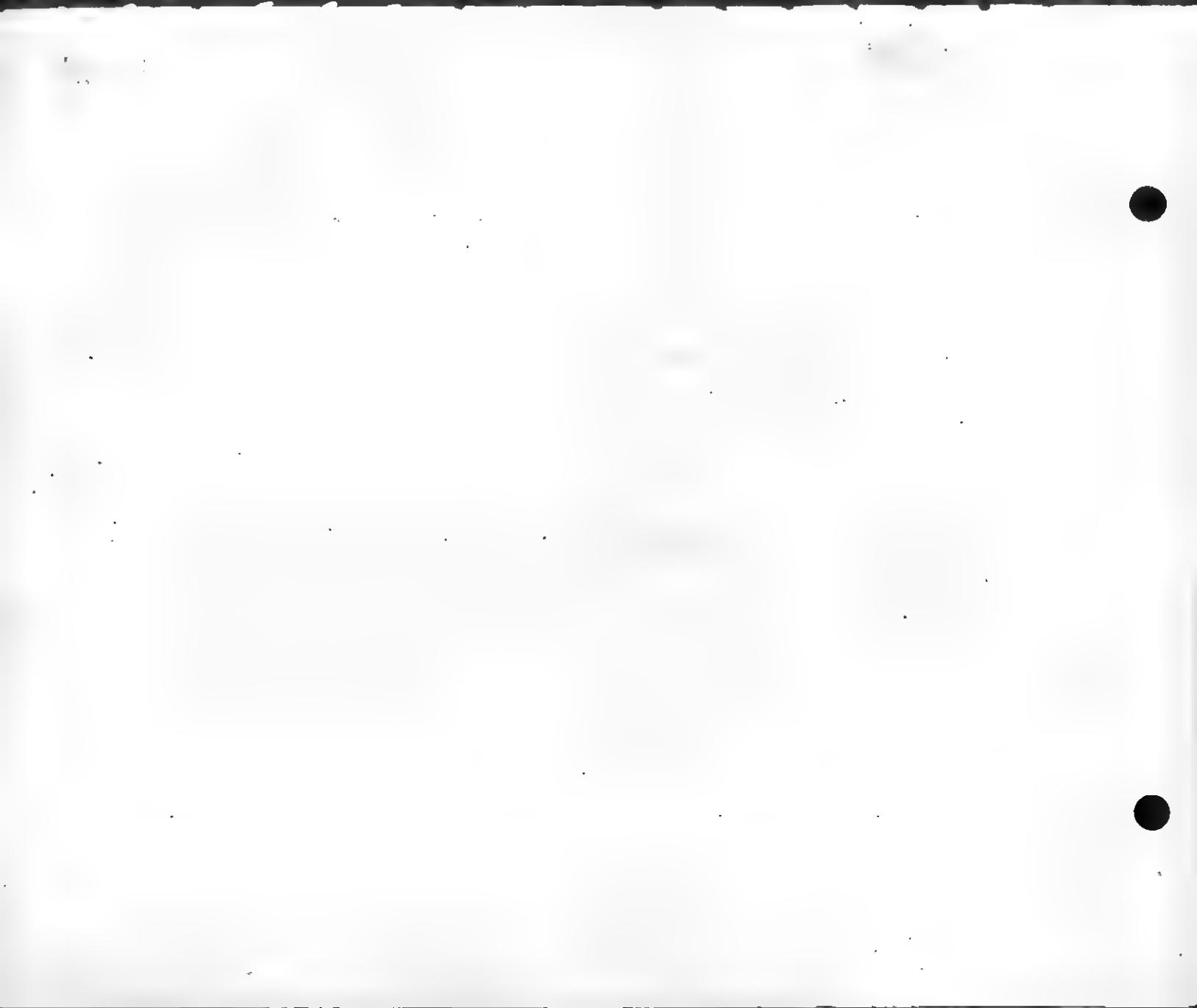
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14534

CERTIFICATE OF DEATH

14534

1. PLACE OF DEATH a. COUNTY <i>Prince George County Maryland</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>P. G.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughtsville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughtsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hyattsville Maryland</i>			
3. NAME OF DECEASED (Type or print) <i>Philip</i>		First <i>Samuel</i>	Middle <i>Brooke</i> Last
4. DATE OF DEATH Month <i>Oct.</i> Day <i>31</i> Year <i>1966</i>		5. SEX <i>M</i>	
6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>9/1/07</i>		9. AGE (In years last birthday) <i>59 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Naval Photographer Gov't</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. D. C.</i>	
11. BIRTHPLACE (County & State, or Foreign country) <i>Wash. D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Eppa Brooke</i>		14. MOTHER'S MAIDEN NAME <i>Steeley</i>	
15. WAS DECEASED EVER A U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <i>Mr Rbt. Cashion 3529 Duke St. College</i>	
17. INFORMANT <input type="checkbox"/>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Chronic Urinary Tract Infection</i> DUE TO (c) <i>Arterosclerotic Cerebrovascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>78 hrs</i> <i>6 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arterosclerotic Cerebrovascular disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>31 Oct. 1966</i>
20f. (City or town) <i>31 Oct. 1966</i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1966, to <i>31 Oct.</i> , 1966, that (I) (we) last saw the deceased alive on <i>31 Oct. 1966</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wm. J. W. Demarest</i>		22b. DATE SIGNED <i>31 Oct. 1966</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-4-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl. Cem.</i>
24. FUNERAL DIRECTOR <i>Lee Funeral Home</i>		23d. LOCATION (City, town or county) <i>Arlington, Va.</i>	
ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR <i>NOV 4 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14535

CERTIFICATE OF DEATH

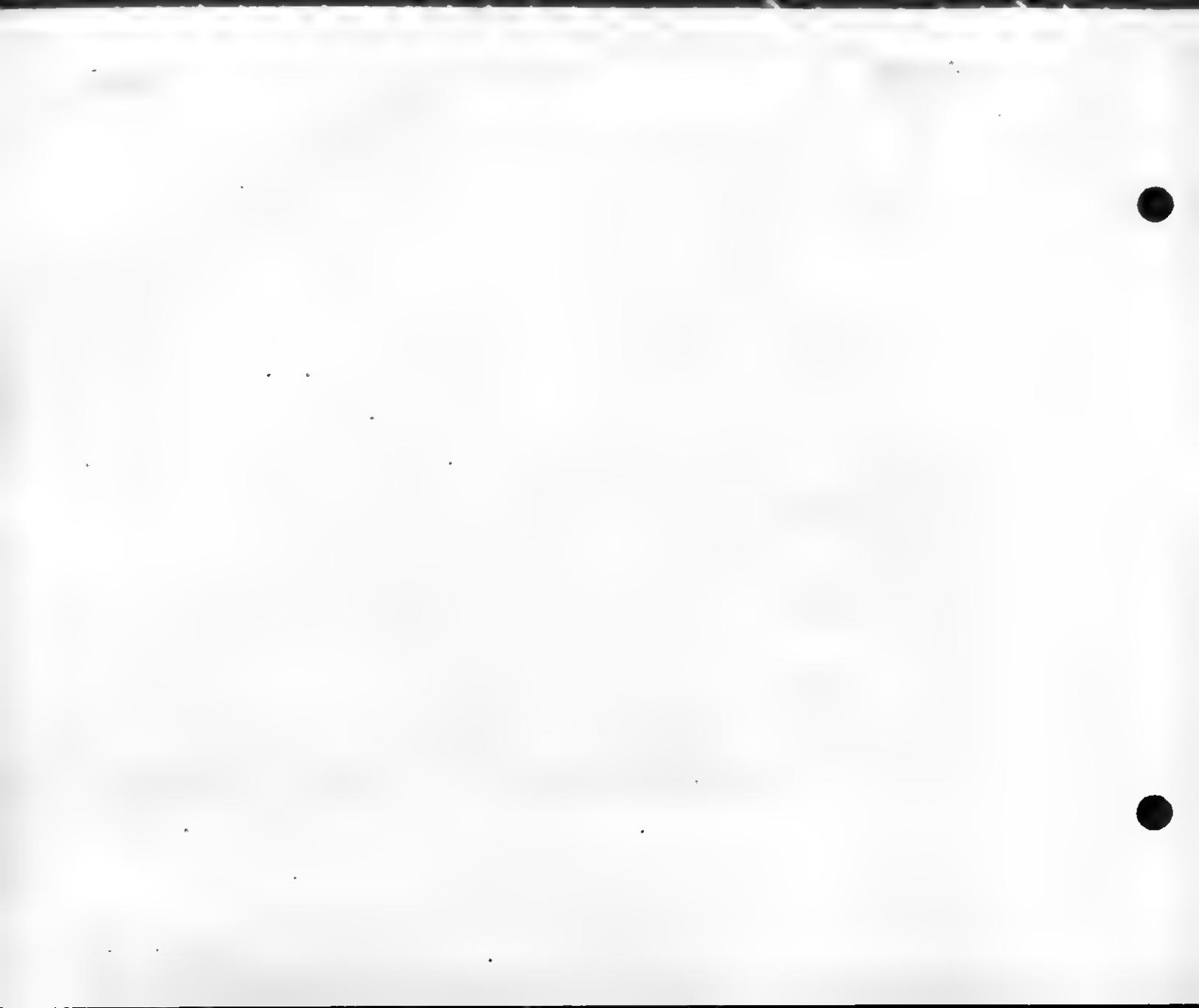
14535

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Howatt Lane		d. STREET ADDRESS Howatt Lane	
3. NAME OF DECEASED (Type or print) First Arthur Middle Buddington Last		4. DATE OF DEATH Oct 19, 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>
9. DATE OF BIRTH June 3, 1886		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Buddington		14. MOTHER'S MAIDEN NAME Dorothy A. Comstock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 218 34 5563	
17. INFORMANT John J. Gude		18. INFORMANT Address Silver Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4207 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		19. INTERVAL BETWEEN ONSET AND DEATH Cerebral Cardio Failure.	
(b) DUE TO Underlying Heart Disease			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from Oct 18, 1966, to Oct 24, 1966, that (I) (we) last saw the deceased alive on Oct 19, 1966, and that death occurred at 11:00 P.M. from causes and on the date stated above.		21b. DATE SIGNED Oct 19, 1966	
22a. SIGNATURE Donald C. Edgren		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Donald C. Edgren		22d. ADDRESS Prince George Plaza - Hyattsville.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 21, 1966	23c. NAME OF CEMETERY OR CREMATORIUM St John's Cemetery
24. FUNERAL DIRECTOR F. Jasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE OCT 24 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16.1. (G) Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14536											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland						b. COUNTY Prince George's																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																							
Mt. Rainier						Mt. Rainier						Mt. Rainier																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
4308 Kaywood Drive						4308 Kaywood Drive						16.1																							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year																								
Eunice T. Womble					Burr	10			10	10	1966																								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH			9. AGE (in years last birthday)			10. FUNDER 1 YEAR			11. FUNDER 24 HRS.																				
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		3-23-1909			57 yrs.			Months			Days			Hours																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?																	
Housewife												VIRGINIA						U.S.A.																	
13. FATHER'S NAME GEORGE P. TWOMBLY						14. MOTHER'S MAIDEN NAME BESSIE BALL						Address 729 S. QUINCY ST. ALEXANDRIA, VA																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES <input checked="" type="checkbox"/> WW II						16. SOCIAL SECURITY NO.						17. INFORMANT MRS LOUISE E. PRINTZ ARLINGTON, VA						INTERVAL BETWEEN ONSET AND DEATH minutes unknown																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22. DATE SIGNED 10-10-66																	
ACTUAL SIGNATURE John Kehoe, M.D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.												Address (Street, city, town, or county)																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL OUT 12 1966						23b. DATE THEREOF						23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS						23d. LOCATION (City, town or county) ARLINGTON, VA																	
24. FUNERAL DIRECTOR WW Chambers Co.																		25a. REGD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 13 1966 Charles Judge																	
VR A15ME 3500 4-64																																			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14537

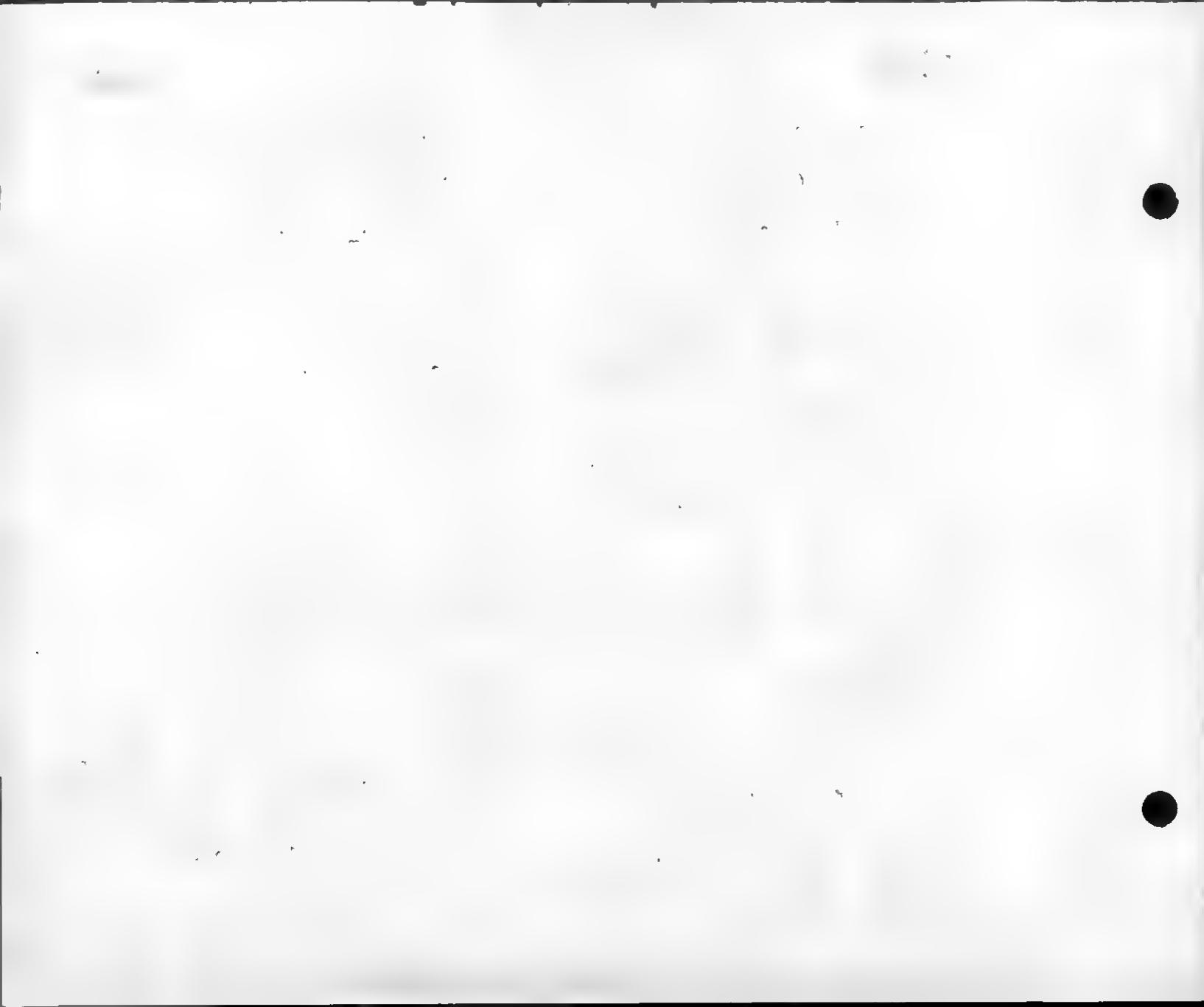
CERTIFICATE OF DEATH

14537

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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 6 mos., 12 days Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 507 N St., N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle E.	Last Butler
4. DATE OF DEATH Month 10	Month 6	Day 19	Year 66
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 12/8/1913	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. U.S. JAL OCCUPAT ON (Give kind of work done during most of work or life, even if retired) Delivery-man	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Jesse Butler		14. MOTHER'S MAIDEN NAME Mattie Lewis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-16-0556	17. INFORMANT Address Decedent
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 7 years	
U.U.U Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/25/1966 to 10/6/1966 that <input type="checkbox"/> (we) last saw the deceased alive on 10/6/1966 , and that death occurred at 6:40 AM , from causes and on the date stated above.		22b. DATE SIGNED 10/6/66	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11/2/66	23c. NAME OF CEMETERY OR CREMATORIAL NATIONAL BURIAL
24. FUNERAL DIRECTOR J. T. Aufrecht		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 20 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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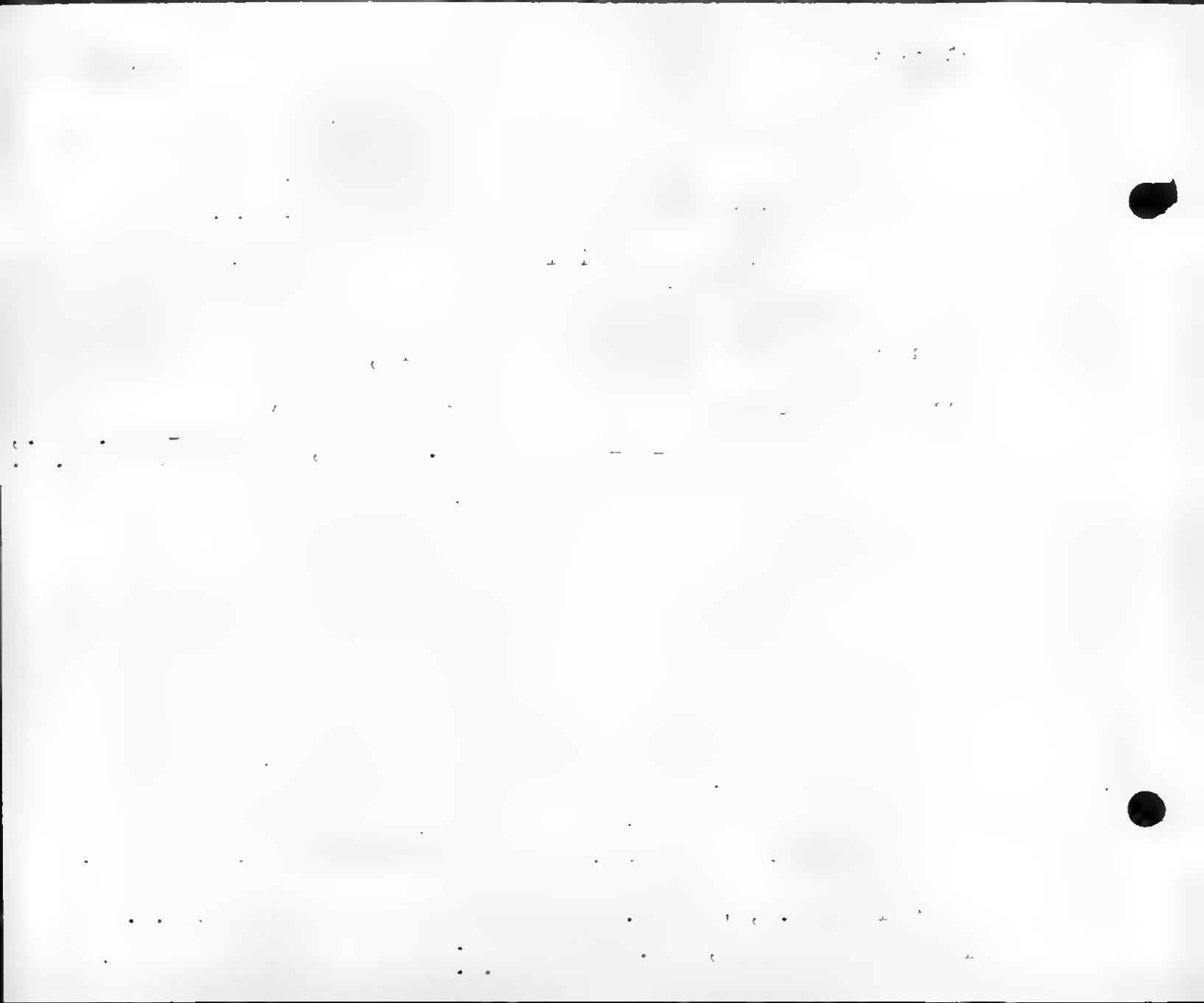
14538

CERTIFICATE OF DEATH

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY 27				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly 65 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1415 52nd Ave., N.E.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Joseph	Middle William	Last Butler			
4. DATE OF DEATH	Month October	Day 1	Year 1966			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/23			
9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (County & State, or foreign country) Waldorf, Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Clay Butler (D)	14. MOTHER'S MAIDEN NAME Gertrude Savoy (D)	Address 1415-52nd. Ave., Beaver Heights, Md.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. 219-12-3519	17. INFORMANT Helen T. Butler, Wife	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) lungating carcinoma middle third of esophagus 150 X DUE TO involving trachea & later lymph nodes		INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Bronchopneumonia (terminal)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year July 28, 1966	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Washington, D.C.	(County) D.C.	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from July 28, 1966 to Oct. 1, 1966 , that (I) (we) last saw the deceased alive on Oct. 1, 1966 , and that death occurred at 9:15M , from the causes and on the date stated above.						
22a. SIGNATURE <i>James W. Harding, M.D.</i>		22b. DATE SIGNED 10-1-66				
22c. PHYSICIAN'S NAME (Type) James W. Harding, M. D.		22d. ADDRESS 7601 Riverdale Rd., Lanham, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 5, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Rollins Funeral Home, Inc.	ADDRESS 4339 Hunt Pl. N.E.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14539

CERTIFICATE OF DEATH

14540

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1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First: Ethel	Middle: M. B	4 DATE OF DEATH Month: Oct Day: 7 Year: 1966
5 SEX Female	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1898 4-17-1898
10a USL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY at Home	
13. FATHER'S NAME Wiliam Richards		14. MOTHER'S MAIDEN NAME Anne Richards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Edward B. Calhoun Address 5900 Knobback Hyatt, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomas DUE TO 173X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mammary Carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (This hospital) attended the deceased from 10-7-66 to 10-8-66 , that (I) (we) last saw the deceased alive on 10-7-66 and that death occurred at 10-8-66 , fram causes and an the date stated above.			
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED Oct 8, 1966	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON		22d. ADDRESS 909 Parshing Dr. Silver Spring, Md	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 11, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Mount Union Cemetery	23d. LOCATION (City or Town) (County) (State) Menokin, Prince
24. FUNERAL DIRECTOR Matthew Leathers		25a. ADDRESS 254 Carroll St. Hyattsville, Md	25b. REC'D BY REGISTRAR DATE OCT 11 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M)

14540

CERTIFICATE OF DEATH

14541

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then, use remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN Tb 1½ years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) Washington, D. C.	
3. NAME OF DECEASED (Type or print) Willis		d. STREET ADDRESS 4708 15th St., N.W.	
First H. Middle Canada Sr.		4. DATE OF DEATH October 8, 1966	
S SEX M	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Wyoming		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Henry Canada		14. MOTHER'S MAIDEN NAME Sally Harrold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Marines 1924-25 579-09-5596		16. SOCIAL SECURITY NO 17. INFORMANT decedent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic cor pulmonale		19. INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO stating the underlying cause (c) far advanced pulmonary tuberculosis		20. 2 yrs., 7mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis; chronic pyelonephritis.		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 5/14/66 to 10/8/66 that (A) (we) last saw the deceased alive on 10/8/66 19_____, and that death occurred at 7:00PM , from causes and on the date stated above.		22b. DATE SIGNED 10/8/66	
22a. SIGNATURE <i>Moe Weiss</i>		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) 13 W.W.		23b. DATE THEREOF 10/13/66	
23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL		23d. LOCATION (City or Town) SOUTHLAND (County) (State) M.D.	
24. FUNERAL DIRECTOR LEE FUNERAL HOME 3004 28T. N.E.		25a. ADDRESS 25b. REGISTRAR'S SIGNATURE Charles Judge	
25a. REC'D BY REGISTRAR DATE OCT 14 1966		25b. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

14541

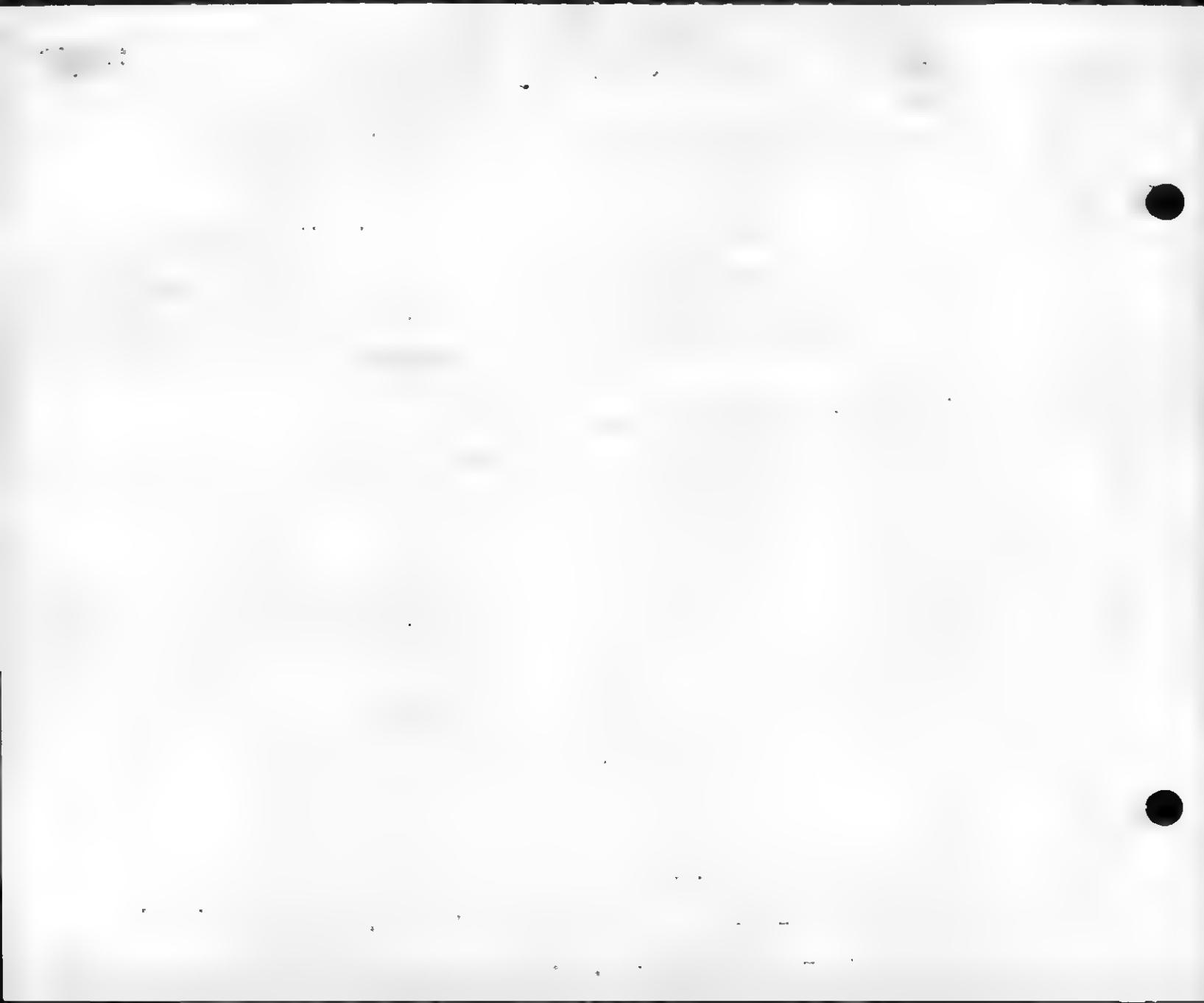
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14542

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First Sheri	Middle Denise	Last Carpenter
4. DATE OF DEATH 10	Month 14	Day 19	Year 66
5. SEX F Negro	6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Sept., 1966
9. AGE (in years last birthday) yrs. 1	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William A. Carpenter	14. MOTHER'S MAIDEN NAME	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT See #13	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X OUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden death in infancy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
MEDICAL CERTIFICATION ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Arlington, Va.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-18-66	23c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat'l Cem.	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. FUNERAL DIRECTOR Frazier's - Washington, D. C.	ADDRESS	25a. REC'D BY REGISTRAR OCT 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designee agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14542

CERTIFICATE OF DEATH

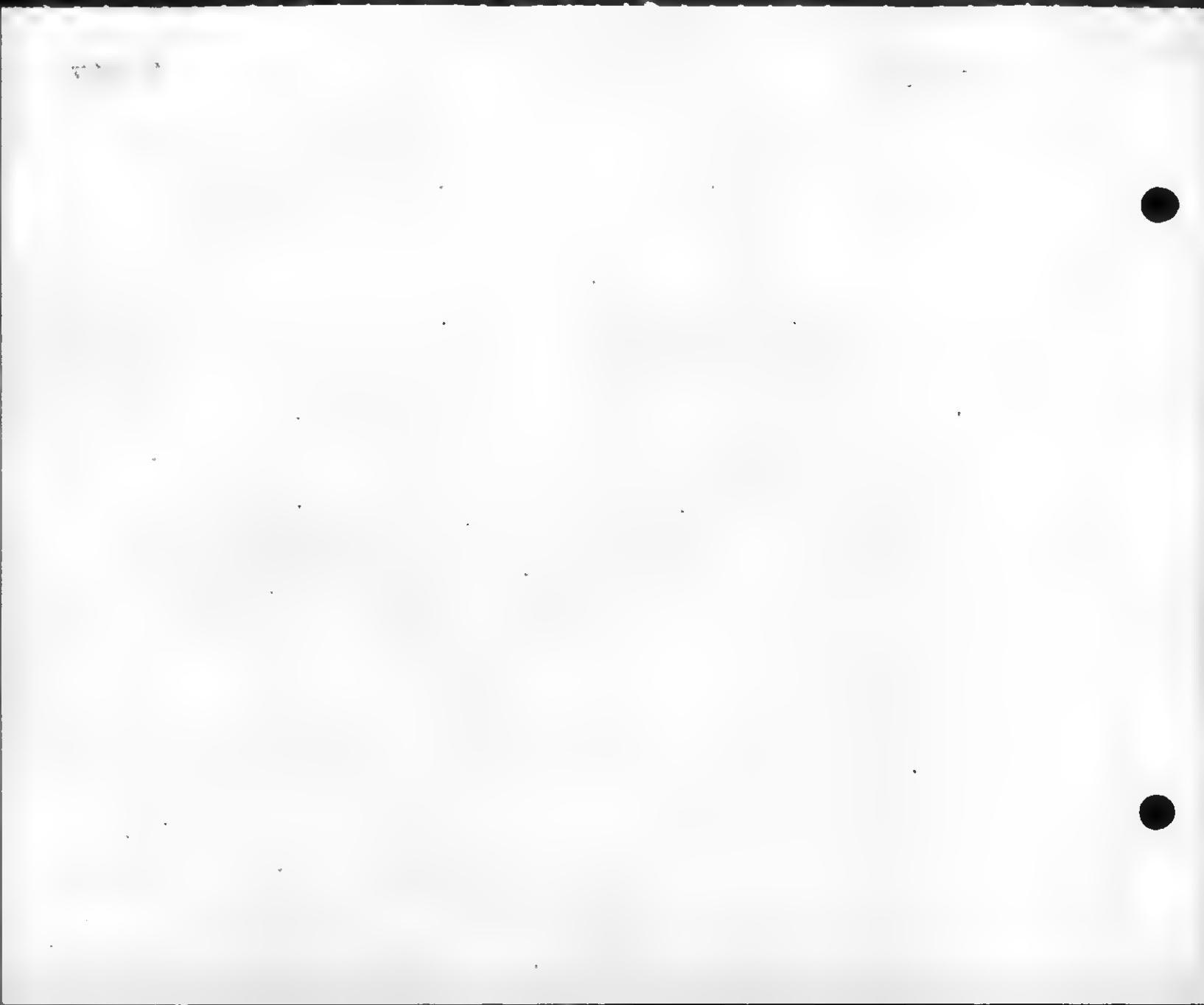
14543

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital			d. STREET ADDRESS 4208- 20th Street			e. S. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ellen		First C.	Middle Catlett	4. DATE OF DEATH October 24, 1966	Month Year	Day Year
S. SEX Fe	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-29-92	9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Tom Williams			14. MOTHER'S MAIDEN NAME Mitchell Bowie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Paul H Catlett, Mt Rainier, Md. & Hospital Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Haemorrhage from Subcapsular Hematoma</u> DUE TO <u>Placental effusion, bilaterally; right pneumonia</u> 2 days Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Aspiration from obstructed esophagus</u> (c) <u>from esophageal stricture + ulcerative esophagus</u> Mouth						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 10-14, 1966, to 10-24, 1966 that (I) (we) last saw the deceased alive on 10-24, 1966 and that death occurred at 9:25 P.M. from causes and on the date stated above.						
22a. SIGNATURE <u>Rowland F Wilkinson</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	M.D. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) Rowland F Wilkinson		22d. ADDRESS Riverdale, Md.				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 27, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1966	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jubb</u>	



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

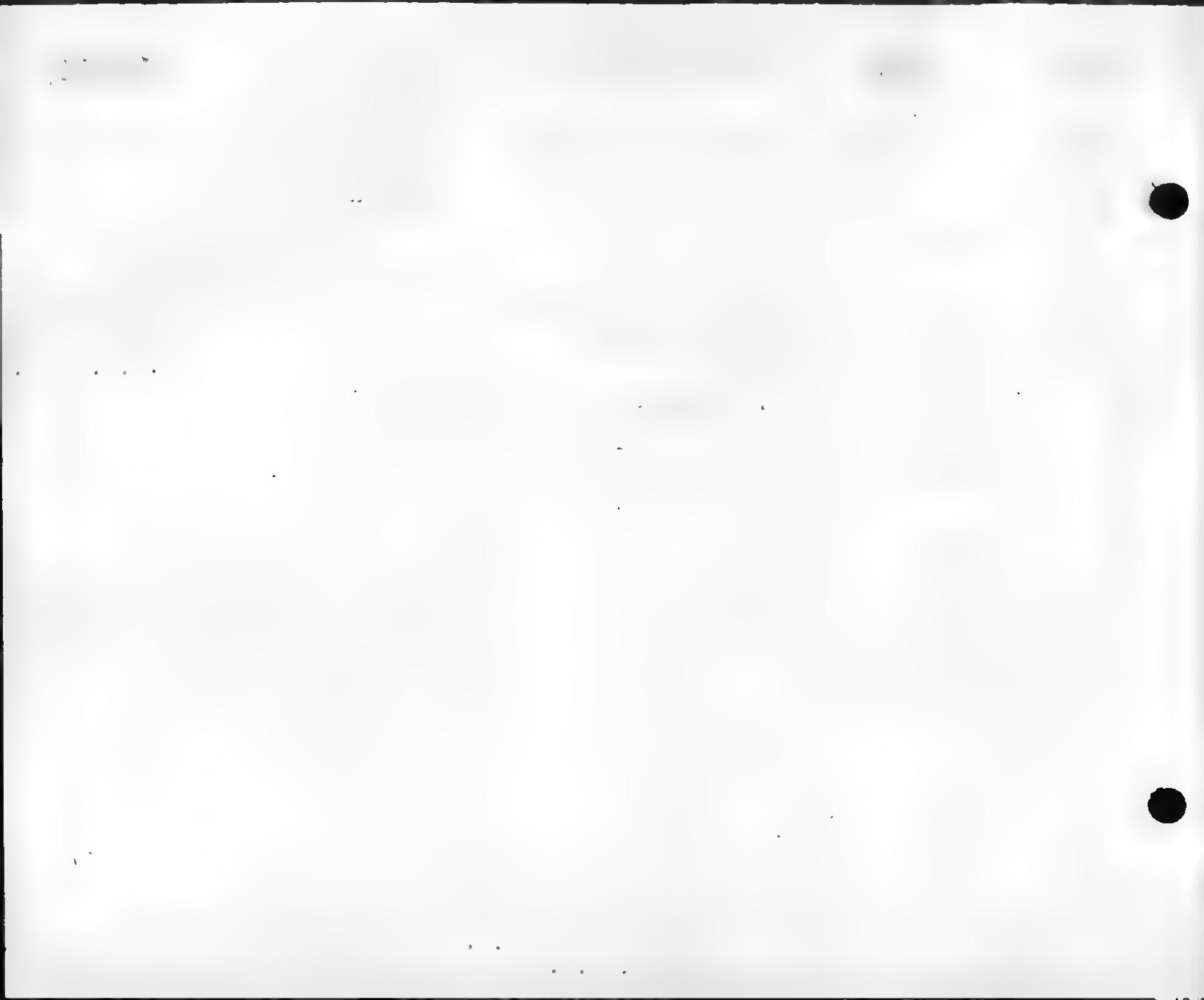
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14544

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Virginia							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b one hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warrenton						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clinton Medical Center			d. STREET ADDRESS c/o Sp-5 Venthill Farm Station			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Palmer	Middle Elvin	Last Christianson	4. DATE OF DEATH October 20	Month 19	Day 66				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1899	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Iowa			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter O. Christianson			14. MOTHER'S MAIDEN NAME Regina Boyd							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No			16. SOCIAL SECURITY NO. 479-10-9712A			17. INFORMANT David Christianson			Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis									hours	
DUE TO Congestive heart failure									years	
DUE TO Coronary arteriosclerotic heart disease									years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Kehoe</i>									CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.									M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
									DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)									22. DATE SIGNED 10-20-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-27-1966			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Story City Memorial 131 11th St S.E.			23d. LOCATION (City, town or county) Story City, Iowa (State)	
24. FUNERAL DIRECTOR <i>Robert M. Maittingly</i>									25a. REC'D BY REGISTRAR DATE OCT 24 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14546

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14545

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If my delay is necessary, please execute the certificate, writing the word "pending" in pencil. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. LENGTH OF STAY IN 1D d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PARK	
37 Walnut Lane, Cherry Hill Trailor		College Park	
3. NAME OF DECEASED (Type or print) Austin		d. STREET ADDRESS Trailor Park.	
4. DATE OF DEATH Month Day Year Clark 10 9 19 66		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Jan. 1889	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotyper		9. AGE (In years last birthday) 77 yrs.	
10b. INDUSTRY Newspaper Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Daniel Austin		14. MOTHER'S MAIDEN NAME Celina M. Eoute	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577 03 2823	
17. INFORMANT Ruth H. Clark Same as #2 (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-10-66	
23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial (Specify) 10/12/66		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.S. Page 5 may be retained for your files.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14545

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14546

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
Prince George's MARYLAND		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 4 hrs. 40min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4919 Naples Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH 10 12 19 66	
Leslie Thomas Clark			
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-1936	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy equipment sand gravel.		10b. KIND OF BUSINESS OR INDUSTRY Bowie Md	
11. BIRTHPLACE (State or foreign country) George Lee Clark		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Lee Clark		14. MOTHER'S MAIDEN NAME Evelyn Lase Carter	
15. WAS DECEASED EVER IN U.S. ARMEED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Grace Clark Beltsville Md	
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left, subarachnoid and interventricular			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) Rupture of Berry aneurysm, left middle cerebral artery			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-13-66	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Gate of Heaven		23d. LOCATION (City, town or county) (State) Wheaton Md	
24. FUNERAL DIRECTOR DeWitt Sandoval Laurel Md		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14546

CERTIFICATE OF DEATH

14547

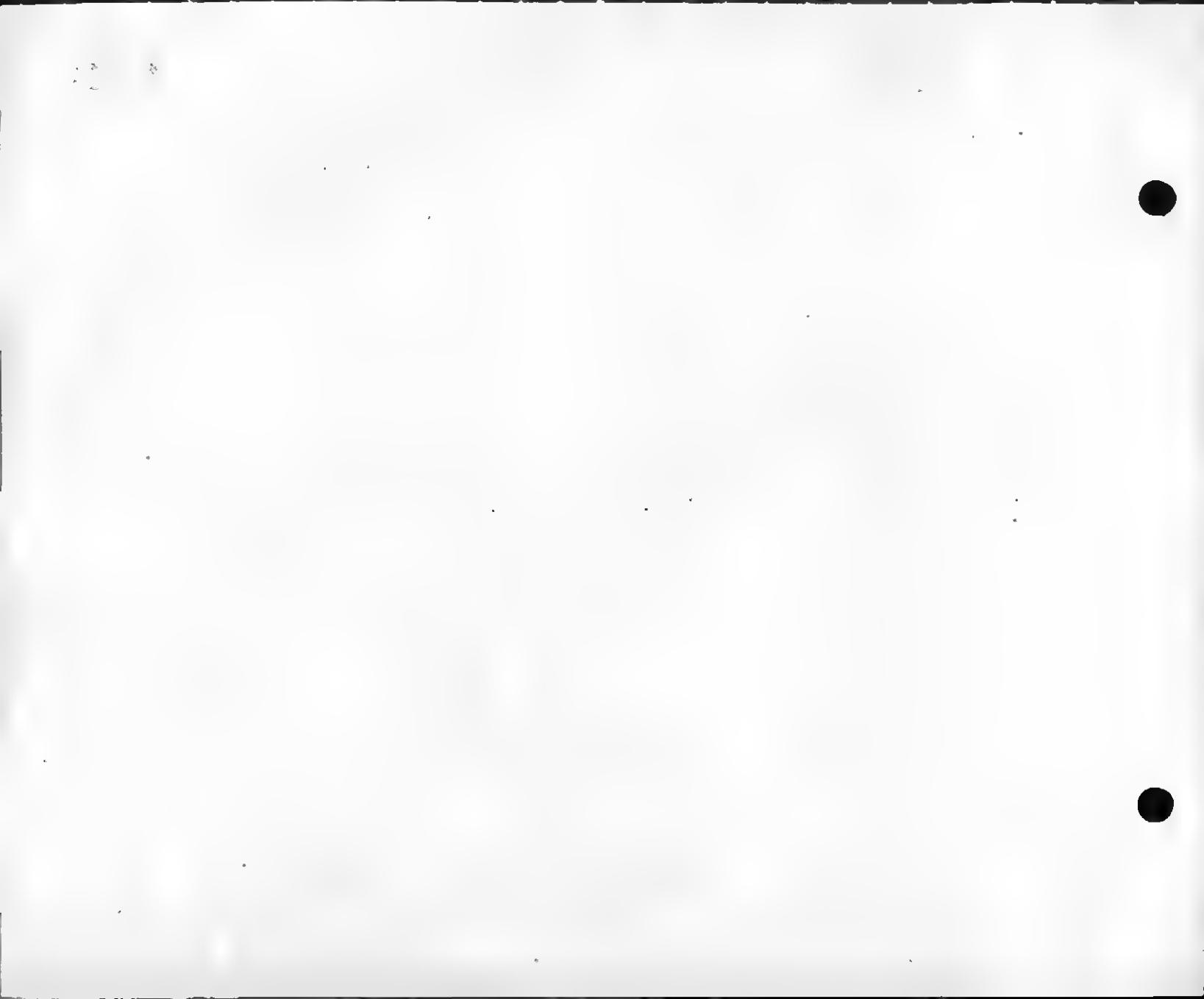
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Deputy Medical Examiner Notified: Dr. John Kehoe

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md.	
c. LENGTH OF STAY IN b 16 -		d. STREET ADDRESS 36 Q. Ridge Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marvin Middle C. Last Cline		4. DATE OF DEATH Month Oct Day 25, Year 66	
5. SEX male 6. COLOR OR RACE white		7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Building		10b. KIND OF BUSINESS OR INDUSTRY contractor	
11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alysses Cline		14. MOTHER'S MAIDEN NAME Alvina --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO. 482 01 5551A.	
17. INFORMANT Edna A Cline		Address Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA xx		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from APRIL, 1966, to 10-25, 1966, that (I) (we) last saw the deceased alive on 10-21 1966, and that death occurred at 12:30 M, from causes and on the date stated above.		22b. DATE SIGNED Oct 25, 1966	
22c. PHYSICIAN'S NAME (Type) Morrill C. Quinnam Jr.		22d. ADDRESS Silver Springs, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

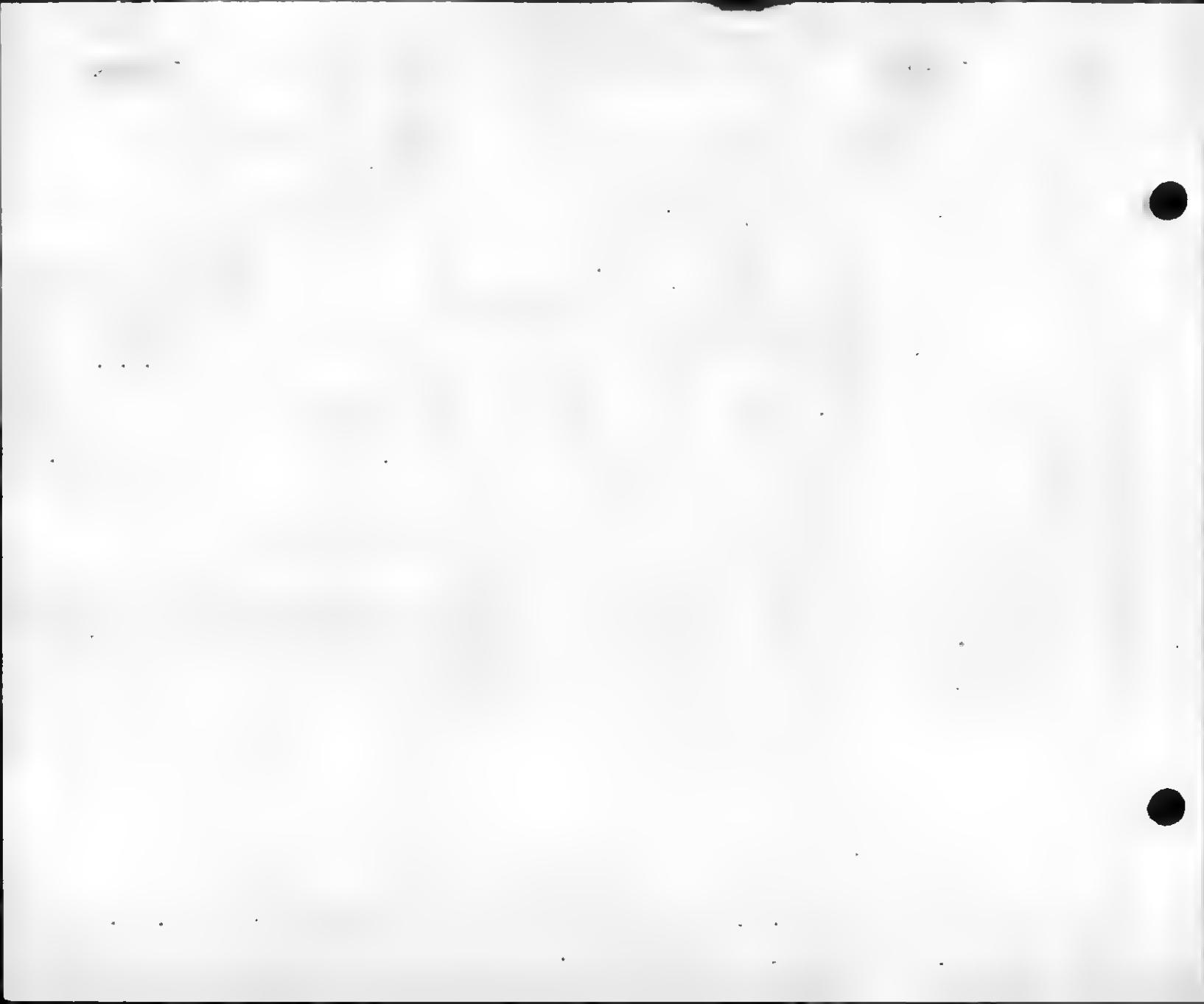
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-4. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return them within 72 hours after death.

1 Items 18-21 Film 381 10-13 66 ams MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **14548**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle P.	Last Clum
4. DATE OF DEATH October 2 1966	Month October	Day 2	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius W. Clum		14. MOTHER'S MAIDEN NAME Mary Greer Herring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220 44 1853	
17. INFIRMANT		Address Katherine G. Clum Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) peritonitis from sigmoid diverticulum (c) blunt trauma to abdomen DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell on a boat	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9-11 p.m. 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) boat
20f. (City or town) Indian River Inlet (County) Del. (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Dayton O'Wat</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O'WATKINS		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 10-4 66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Union Cemetery
23d. LOCATION (City, town or county) Rockville, Mont. Co. Md.		25a. REC'D BY REGISTRAR Rockville, Mont. Co. Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons, Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles J. Gege	



1
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14548 CERTIFICATE OF DEATH 14549

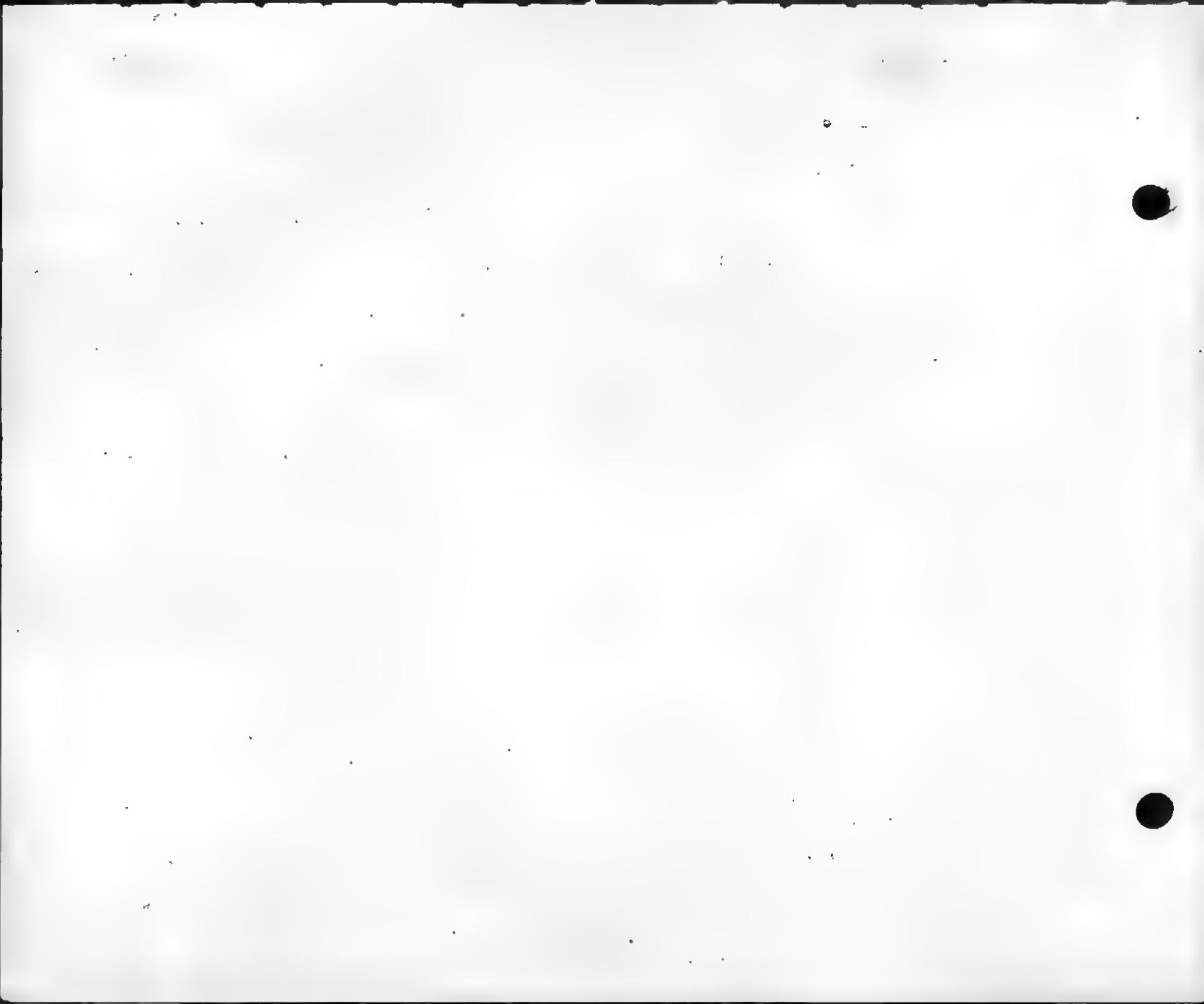
1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 5704 Old Branch Avenue			b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First William	Middle R.	Lost Colegrove	4 DATE OF DEATH October 23 1966	Month Year	Day Year	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1895	9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Colegrove			14. MOTHER'S MAIDEN NAME Emma Rabbit				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO			17. INFORMANT Address William C. Colegrove 3416 Brinkley Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			19. INTERVAL BETWEEN ONSET AND DEATH Carcinoma of Parotid Gland, left				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO C Metastasis to lymph nodes of neck & mediastinum			6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-12, 1966, to 10-23, 1966, that (I) (we) last saw the deceased alive on 10-14 1966, and that death occurred at 10:00 A.M. from causes and on the date stated above.							
22a. SIGNATURE John P. D'Angelo M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-24-66	
22c. PHYSICIAN'S NAME (Type) John P. D'Angelo M.D.		22d. ADDRESS 3508 Branch Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland		25a. REC'D BY REGISTRAR DATE OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
14549				14550											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington											
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 1301 Vermont Avenue, N.W.											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Cornelia				First	Middle	Last	4. DATE OF DEATH October 9 1966	Month	Day	Year					
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1888	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretarial				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Lyons, New York				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Mervin Matthew Compson				14. MOTHER'S MAIDEN NAME Emma McGowen											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. 578-03-4643				17. INFORMANT Sacred Heart Home, W. Hyattsville, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Hypertensive heart disease & congestive failure								INTERVAL BETWEEN ONSET AND DEATH 2 years			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				OUE TO (b)				OUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1966, to Oct 9, 1966, that (I) (we) last saw the deceased alive on Oct 7, 1966, and that death occurred at M, from the causes and on the date stated above.												22d. DATE SIGNED 10-9-66			
22a. SIGNATURE Thomas F. Collins MD				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. ADDRESS 322-H ST. N.E. WASH. D.C.			
22c. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS															
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-13-66				23c. NAME OF CEMETERY OR CREMATORIALY				23d. LOCATION (City, town or county) (State) LYONS, NEW YORK			
24. FUNERAL DIRECTOR				ADDRESS 6130 WIS. AVE, N.W. JOSEPH GANLER'S SONS, WASHINGTON, D.C.								25a. REC'D BY REGISTRAR OCT 13 1966			
												25b. REGISTRAR'S SIGNATURE Marilyn Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14550

14551

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Md	
Laural - Rural		20 yrs		b. COUNTY Prince Geo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Oney Lane		Laural - Rural		10-1	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Oct 29 1966
Grace		A.	Connell		Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/30/1882	83 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Housewife		Penns.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James S. Smith		Clemelia E.		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		577-09-7765-B		Thomas B. Connell same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Due to <i>Acute myocarditis</i> (c) Due to <i>Chronic myocarditis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from <i>11/1/1965</i> to <i>10/29/1966</i> , that (I) (we) last saw the deceased alive on <i>10/29/1966</i> , and that death occurred at <i>9 PM</i> , from the causes and on the date stated above					
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
<i>Robert S. Macanay</i>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Laurel, Md. Robert S. Macanay M.D.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2 November 1966		23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEM.	
				23d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <i>Harold S. Nade, 550 Wash. Blvd., Laurel, Maryland</i>		25a. REC'D BY REGISTRAR DATE NOV 4 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

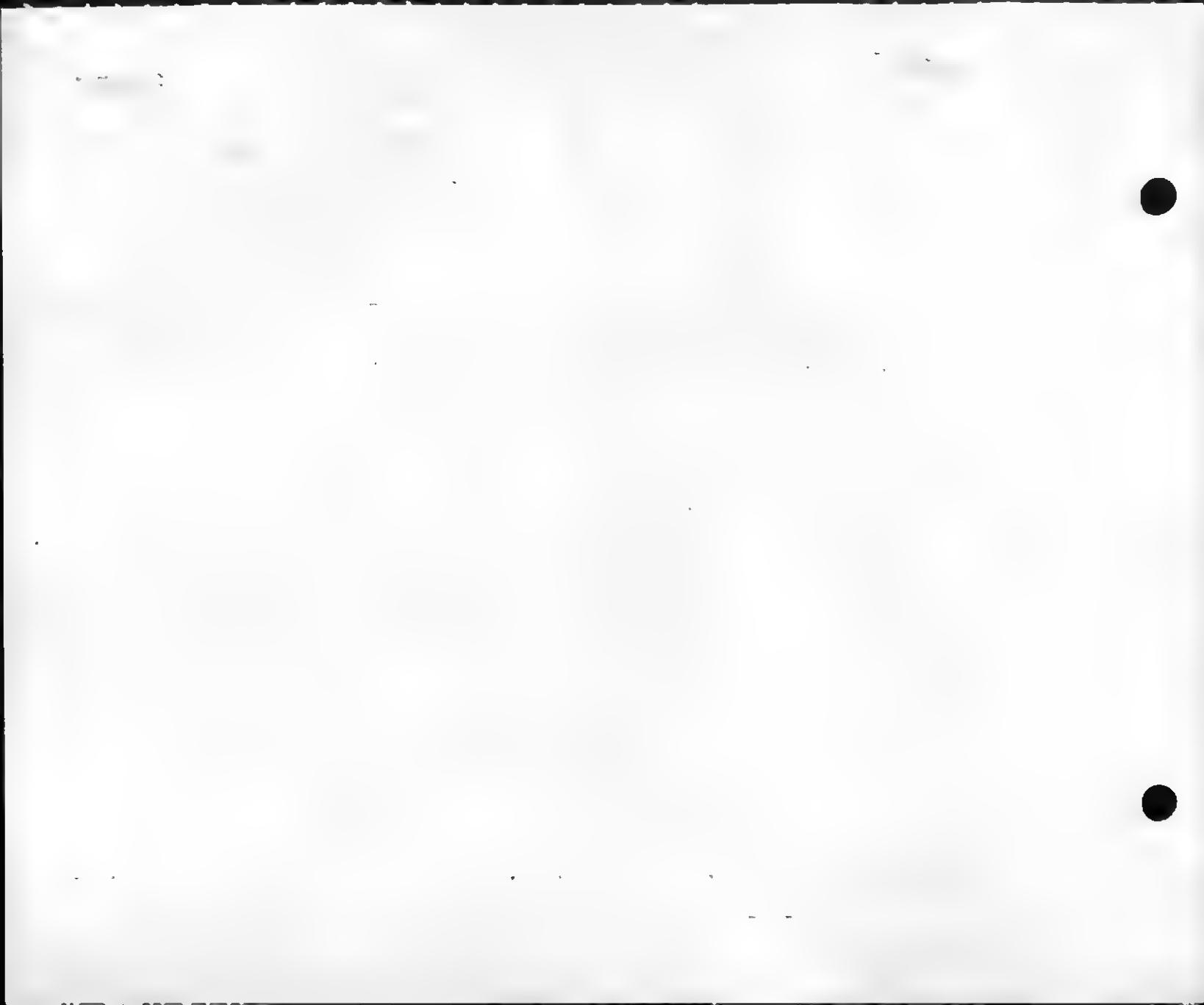
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal. File page 5 with any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14552

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		d. STREET ADDRESS 5632 Fargo Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle Jacob	Last Corman
4. DATE OF DEATH	10	Month 23	Day 19
5. SEX	6. COLOR OR RACE Male White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
9. AGE (In years last birthday) 82 yrs.	10. DATE OF BIRTH 4-5-84	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Corman		14. MOTHER'S MAIDEN NAME Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Eloise C. Boyette		Address 5632 Fargo Ave Oxon Hill Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH MINUTES over 5 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-24-66	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Cole Camp Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-28-66	
23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		23d. LOCATION (City or Town) Cole Camp (County) Missouri (State)	
24. FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Rd Suitland Maryland	
25a. REC'D BY REGISTRAR DATE OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

14552

CERTIFICATE OF DEATH

14553

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN lb <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eugene Leland Mem Hosp</i>		d. STREET ADDRESS <i>1305 Savannah St. S.E.</i>	
3. NAME OF DECEASED (Type or print) <i>Maude Taylor Davis</i>		4. DATE OF DEATH <i>October 24 1966</i>	Month Day Year
S SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. DATE OF BIRTH <i>5/31/1886</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. MOTHER'S MAIDEN NAME <i>Elizabeth Townsend</i>		12. CITIZEN OF WHAT COUNTRY? <i>Georgia U.S.A.</i>	
13. FATHER'S NAME <i>Wm. H. Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Townsend</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>416-09-0480</i>	
17. INFORMANT <i>Elizabeth Crouse</i>		Address <i>Same #7</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Uremia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
DUE TO (b) <i>Uremia</i>		+ 1 week	
DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> 19 p.m. <i>—</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20e. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 5, 1965</i> , to <i>October 24 1966</i> , that (I) (we) last saw the deceased alive on <i>October 23, 1966</i> , and that death occurred at <i>640 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Walcott W. Gibson</i>		22b. DATE SIGNED <i>Oct. 24-1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Walcott W. Gibson, M.D.</i>		22d. ADDRESS <i>4300 St Barnabas Road Marlton Heights, Maryland 20031</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-27-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Alta Vista Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Gainesville, Georgia</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS	
Simmons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14554

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY ERIE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Erie 71	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 1126 East 26th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Leroy	Last Dedrick
4. DATE DEATH	Month October	Day 7	Year 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 3-3-15	9. AGE (in years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER-BUCYRUS-ERIE CORP.		11. BIRTHPLACE (State or foreign country) KANSAS CITY, KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN DEDRICK		14. MOTHER'S MAIDEN NAME IVA McCULLOUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT 175-09-5276 PAULINE DEDRICK, 1126 E. 26 ST., ERIE, PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes	
4xur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease		unknown	
OUE TO (b) OUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus over 20 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 10-8-66			
23a. BURIAL & REMOVAL (Specify) Burial		23b. DATE THEREOF 10-11-1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CALVARY CEMETERY		23d. LOCATION (City, town or county) (State) MILLGREEK TWSP., ERIE CO., PA.	
24. FUNERAL DIRECTOR Nalleys Funeral Home 3200 R.I. Ave. Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE OCT 11 1966 Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M)

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

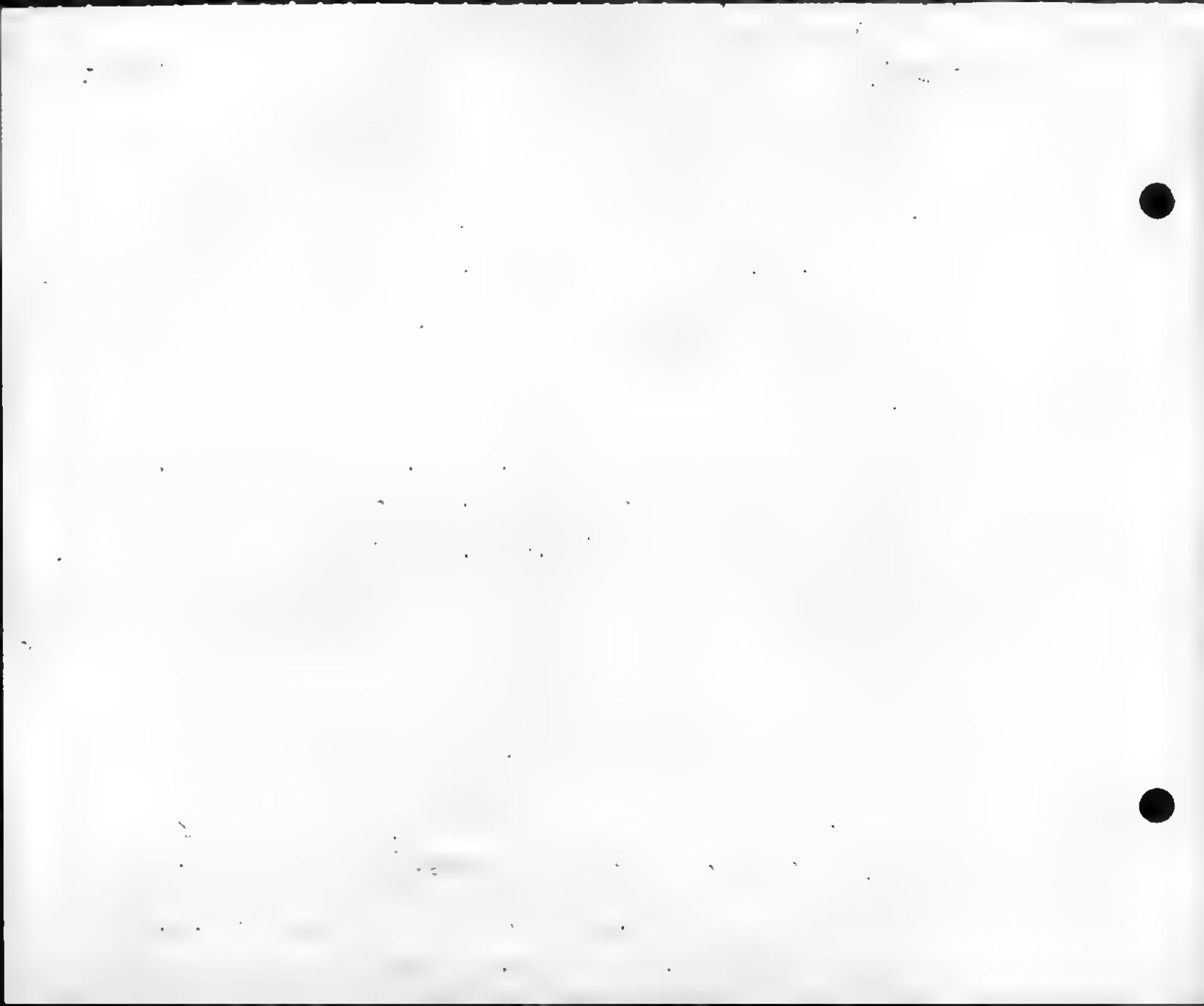
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14554

CERTIFICATE OF DEATH

14555

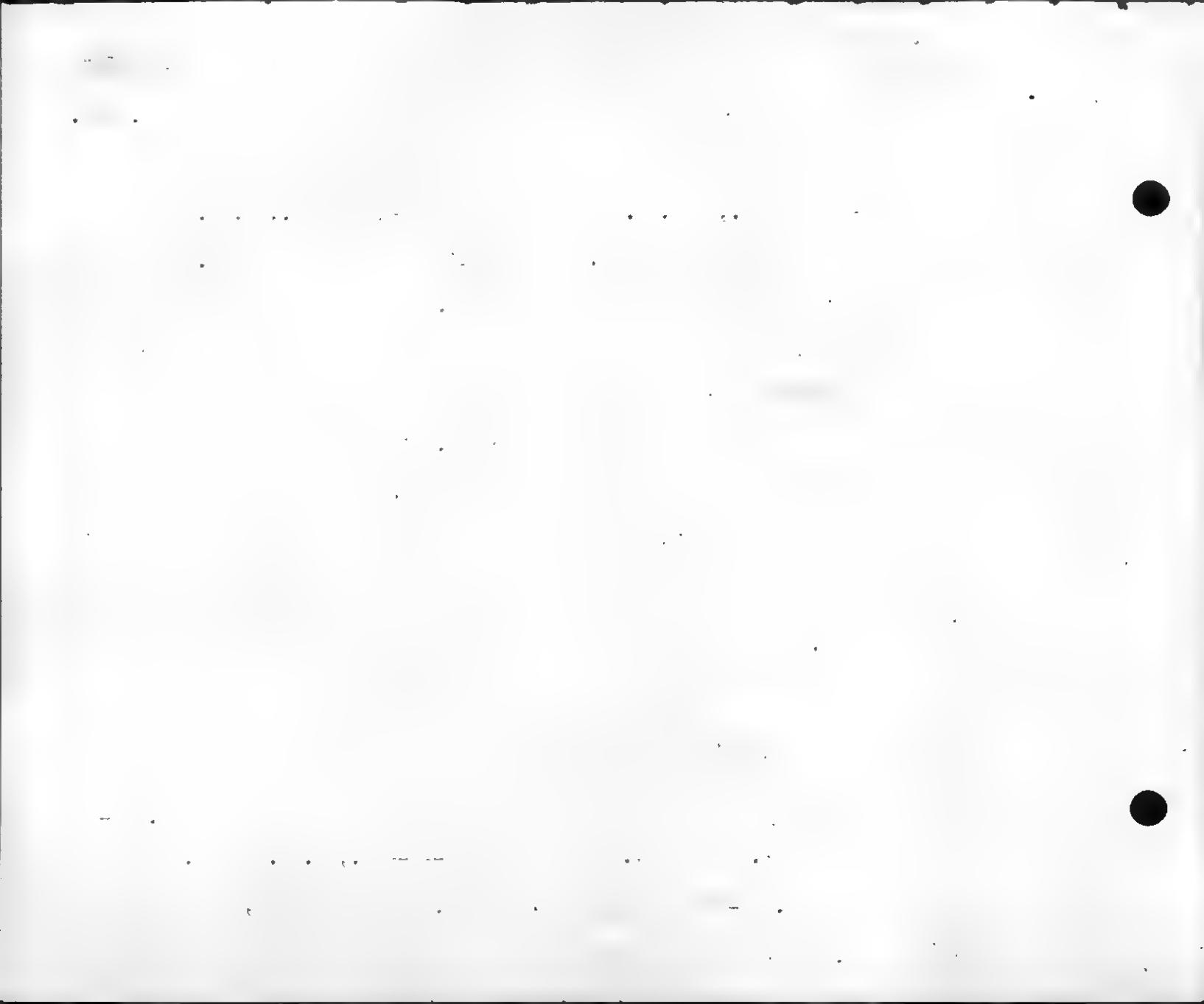
1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3806 75 Avenue		d. STREET ADDRESS 3806 75 Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Pasqua	First	Middle	Last
4. DATE OF DEATH 10	Month	Day	Year 3 1966
5 SEX Female	6. COLOR OF RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 2, 1884		9. AGE (In years last birthday) 82 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Manganaro		14. MOTHER'S MAIDEN NAME Josephine Manganaro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Mrs. Rose M. Mammano 3806 75 Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH immediate 4201 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) Arteriosclerotic Heart Disease (c) 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 7, 1963 , to Oct. 3, 1966 , that (I) (we) last saw the deceased alive on June 14, 1963 , and that death occurred at 8 1/2 M , from causes and on the date stated above			
22a. SIGNATURE W.B. Sheer		22b. DATE SIGNED 10-2-66	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 6400 MARLBORO PIKE S.E. District Heights, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd., Suitland Md.		25a. REC'D BY REGISTRAR OCT 3 1966	25b. REGISTRAR'S SIGNATURE Walter B. Sheer



2
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										14556																					
CERTIFICATE OF DEATH																															
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.																												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside			d. STREET ADDRESS 1325-56th Ave., S. E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1325-56th Ave., S. E.																															
3. NAME OF DECEASED (Type or print) First M. Last LINA M. DiGiulian			4. DATE OF DEATH Oct. 24th 1966			5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5 Jan. 1902			9. AGE (In years last birthday) 64 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME XXXXX John Tron			14. MOTHER'S MAIDEN NAME Jeanne Pascal																												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Alfeo P. DiGiulian Same as Item #2			Address																						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1530 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			Carcinomatous Generalized						INTERVAL BETWEEN ONSET AND DEATH 1 year																						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)																						
21. I certify that (I) (this hospital) attended the deceased from 1959, 19, to 10/24, 1966, that (I) (we) last saw the deceased alive on 10/23, 1966, and that death occurred at 5 A. M., from the causes and on the date stated above.																											22b. DATE SIGNED Oct. 24 1966				
22a. SIGNATURE Charles V. Pate			22c. PHYSICIAN'S NAME (Type) Dr. Charles V. Pate			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22d. ADDRESS 335 N St., N. E. Wash. DC																						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 27-1966			23c. NAME OF CEMETERY OR CREMATORIUM Presbyterian Cem.			23d. LOCATION (City, town or county) Valdese, North Carolina															(State)							
24. FUNERAL DIRECTOR Simmons Bros.			ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC						25a. REC'D BY REGISTRAR DATE OCT 25 1966			25b. REGISTRAR'S SIGNATURE Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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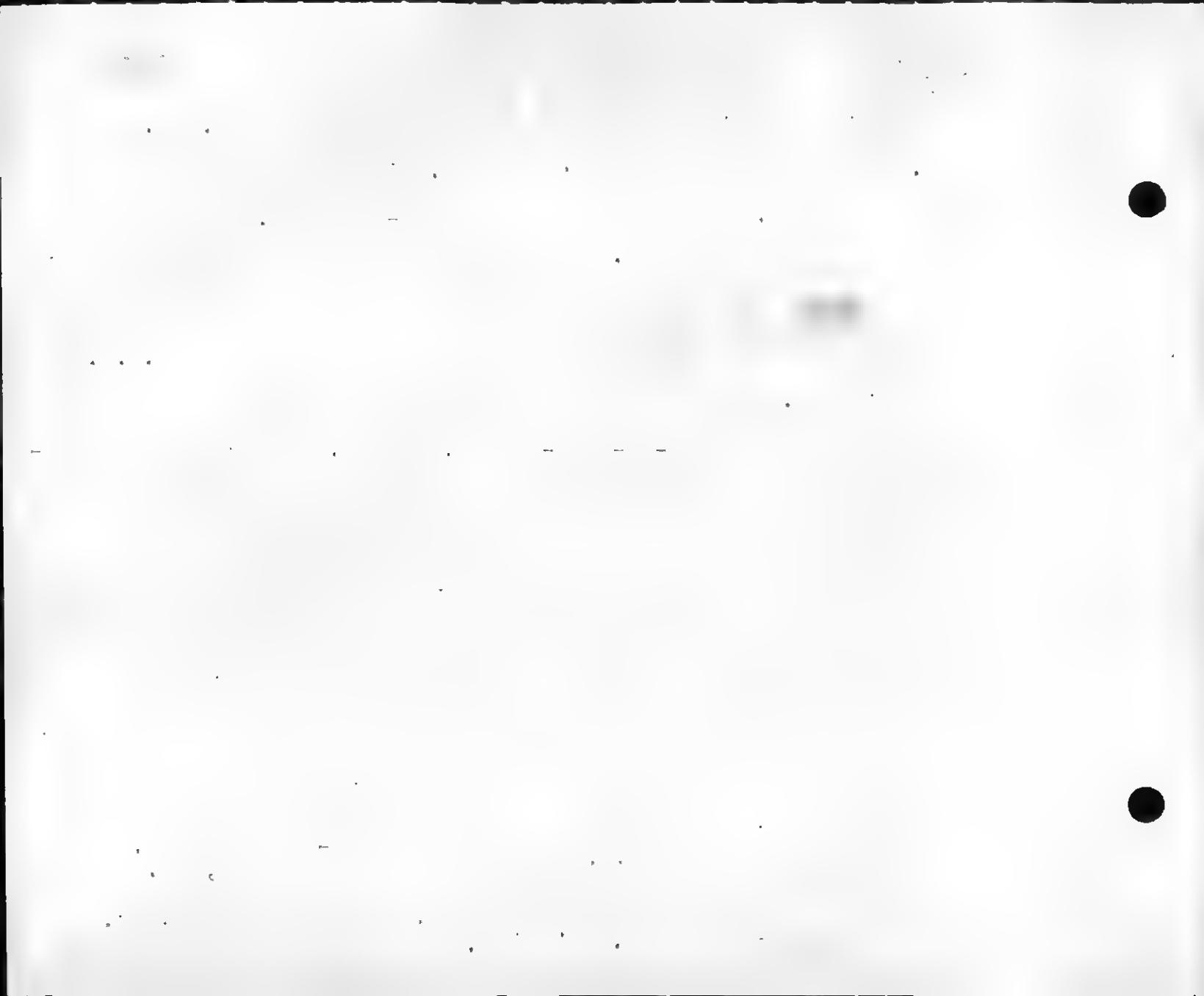
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14556

CERTIFICATE OF DEATH

14557

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN 1b 9 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4206 - 31st St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Otis	First H.	Middle Easterday	4. DATE OF DEATH 10 / 1 / 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/1887	9. AGE (In years at last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William A. Easterday			14. MOTHER'S MAIDEN NAME Annie Parsons		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 231-38-5803-A	17. INFORMANT Mrs. Mary E. Easterday (above address)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			(Wife) dress) Respiratory insufficiency Pulmonary emphysema & fibrosis INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4-5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from 7-16, 1966, to 10-1, 1966, that (I) (we) last saw the deceased alive on 9-30, 1966, and that death occurred at 545 M, from the causes and on the date stated above.					
22a. SIGNATURE Jason Geiger, M.D.					
22c. PHYSICIAN'S NAME (Type) Jason Geiger, M.D.		22d. ADDRESS 800 - Pershing Dr. Silver Spring, Md.	22e. ATTENDING PHYS. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22f. DATE SIGNED 10-1-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/4/66	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.	23d. LOCATION (City, town or county) Colmar Manor, Md.	(State)
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. ADDRESS Mt. Rainier Md.	25b. REC'D BY REGISTRAR OCT 5 1966	25c. REGISTRAR'S SIGNATURE Charles Judge	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14557

CERTIFICATE OF DEATH

14558

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Prince Georges</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>	c. LENGTH OF STAY IN 1b <i>D.O.A.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>	d. STREET ADDRESS <i>9109 Springhill Lane</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robert Clay</i>	First <i>Robert</i>	Middle <i>Clay</i>	4. DATE OF DEATH <i>Edson, SR. October 22 1966</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 3, 1906</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nat'l Dir. Disaster Saw. Amer. Red Cross</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>St. Joseph, Missouri</i>	11. BIRTHPLACE (County & State, or foreign country) <i>U. S. A.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Address 9109 Springhill Lane Greenbelt, Md.</i>		
13. FATHER'S NAME <i>Walter Edson</i>	14. MOTHER'S MAIDEN NAME <i>Katherine Drake</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>490-36-8171</i>	17. INFORMANT <i>Mrs. Ruth Edson</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		
f.201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO <i>Coronary sclerosis</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20d. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1966</i>	20f. (City or town) <i>10/22/66</i>	(County) <i>10/22/66</i>	(State) <i>10/22/66</i>
21. I certify that (I) (this hospital) attended the deceased from <i>9-23/66</i> , 19 <i>66</i> , to <i>10/22/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/7/66</i> , 19 <i>66</i> , and that death occurred at <i>50</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>Louis Ross</i>	22b. DATE SIGNED <i>10/24/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Louis Ross, M.D.</i>	22d. ADDRESS <i>1712 Eye St. NW, Wash. DC, 20006</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Oct. 26, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Rockville, Maryland</i>		
24. FUNERAL DIRECTOR <i>Clark E. Wilson</i>	25a. REC'D BY REGISTRAR <i>Oct 27 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
<i>Warren E. Murphy, Inc.</i>	<i>8434 Georgia Ave.</i>	<i>Silver Spring, Md.</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14558

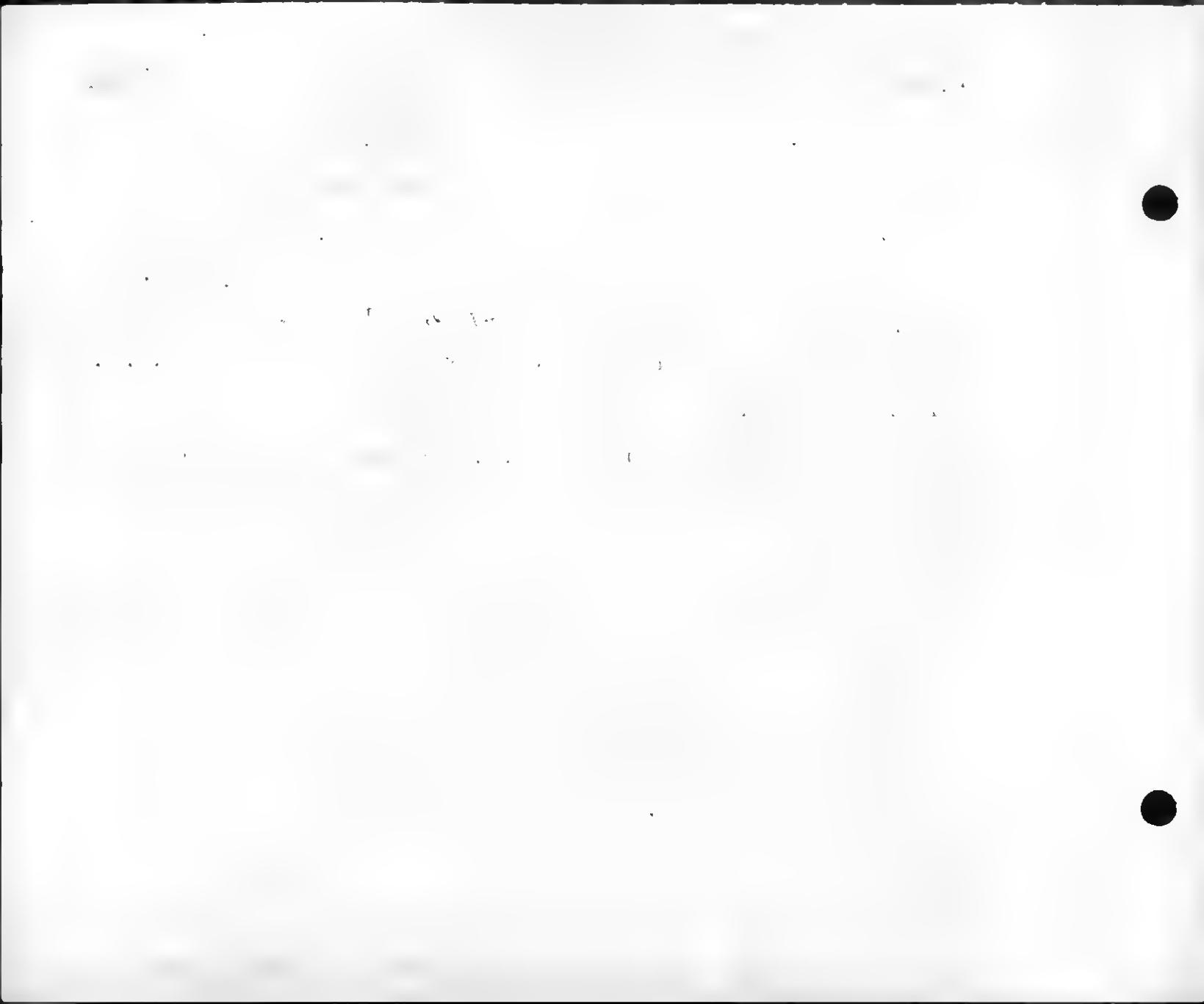
CERTIFICATE OF DEATH

14558

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. General Hospital		d. STREET ADDRESS 6005 38 Place	
3. NAME OF DECEASED (Type or print) Edith M. Edwards		First	Middle
4. DATE OF DEATH Oct. 22, 1966		Month	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH May 23, 1907
9. AGE (In years at death) 59 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during day or, if ever, if retired) Housewife		10b. KIND OF BUSINESS OR AND IS IT Own Home Co.	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME William Thompson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 214 30 0705	
17. INFORMANT L. D. Edwards Same as #2 (husband)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary edema : Bilateral hydrothorax		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/21, 1966 to 10/22/66 19 , that (I) (we) last saw the deceased alive on 10/22 1966 , and that death occurred at 7:15PM , from causes and on the date stated above.			
22a. SIGNATURE Roger B. Edwards		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/23/66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) 13Burial		23b. DATE THEREOF 10/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln
24. FUNERAL DIRECTOR F. Jasch's Sons. Hyattsville, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 26 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14559

11560

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE		
Prince George MARYLAND		Md. Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY		
Cheverly DOA		Brandywine		
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Prince George General Hospital		Box 71		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
	Warren	Patrick	Edwins	
4. DATE OF DEATH	Month	Day	Year	
	10	7	1966	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	28 July 1953	
9. AGE (In years last birthday)	10. FUNDER 1 YEAR	11. UNDER 24 HRS	Months Days Hours Min.	
13 yrs.	Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
STUDENT	SCHOOL	WASHINGTON, D.C.	U.S.A.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address		
WILLIAM EDWINS	SHASTA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH	
NO	NONE	WILLIAM EDWINS, BRANDYWINE, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				
DUE TO Laceration of brain, and				
Fracture of rt. femur,				
DUE TO Traumua-auto accident				
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.				
DUE TO (b)				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
Struck by car while walking along road.				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 a.m. 10 79 66		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) St. rt. 381 Brandywine, P.G.	
		20f. (City or town)	(County) (State)	
		Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22. DATE SIGNED	
John Kehoe, M.D., Riverdale			10-9-66	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town or county) (State)
BURIAL		10-12-66	ARLINGTON NAT.	ARLINGTON, VA
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
The Hunt Funeral Home, Waldorf, Md.		DATE OCT 14 1966		Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

M

14560

CERTIFICATE OF DEATH

14561

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11330 CHERRY HILL ROAD		d. STREET ADDRESS 11330 CHERRY HILL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle CLARK	Last ELLIOTT
4. DATE OF DEATH	Month Oct	Day 25	Year 1966
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 2 JUNE 1913
9. AGE (In years last birthday) 53 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Days 0
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD TRAINMAN		10b. K ND OF BUSINESS OR INDUSTRY WASH. TERMINAL	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME GEORGE C. ELLIOT		14. MOTHER'S MAIDEN NAME BESSIE BRADY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 719 01 3047	
17. INFORMANT G. CLARK ELLIOTT		Address 4664 WICUMICO AV BELTSVILLE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 7201		INTERVAL BETWEEN ONSET AND DEATH months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis		6 years.	
DUE TO (c) Coronary sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 to October 25, 1966 , that (I) (we) last saw the deceased alive on October 25, 1966 , and that death occurred at 10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Hans Wobak		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 10-26-1966
22d. ADDRESS GREENBELT, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 28 Oct 1966	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Maryland		23d. LOCATION (City or Town) (County) (State) WHEATON, MARYLAND	
ADDRESS		25a. REC'D BY REGISTRAR OCT 31 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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M

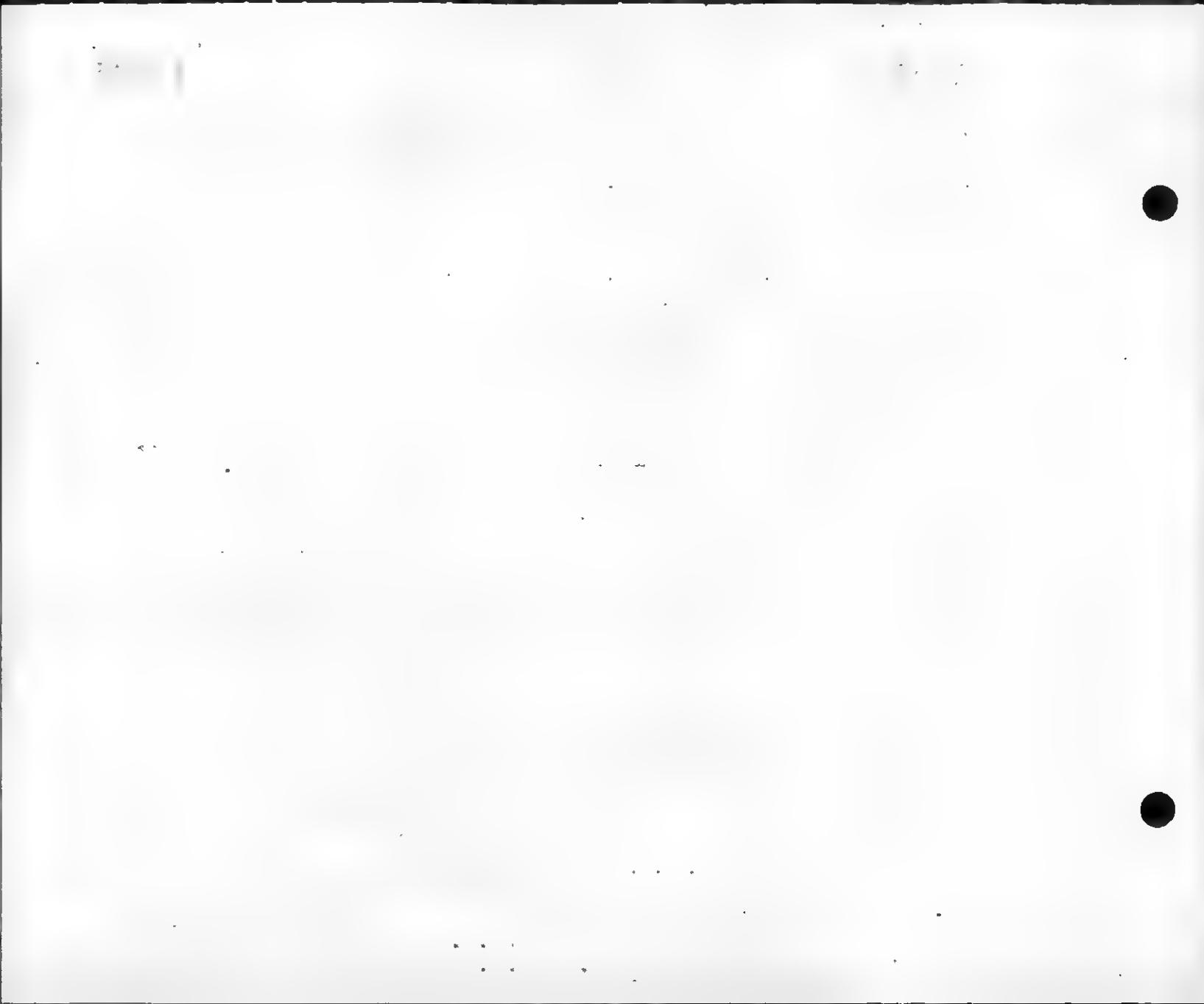
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14561

CERTIFICATE OF DEATH

14562

1. PLACE OF DEATH a. COUNTY Prince Georg'es MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 mo. 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Dorothy	Middle L.	Last Emard
4. DATE OF DEATH October 13 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH July 7, 1927	9. AGE (In years last birthday) 39 yrs	F UNDER 1 YEAR Months 3 Days 6	IF UNDER 24 HRS. Hours 6 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY	10b. KIND OF BUSINESS OR INDUSTRY SECRETARIAL	11. BIRTHPLACE (County & State, or foreign country) LaJunta, Colorado	12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME OTIS FLINN		14. MOTHER'S MAIDEN NAME BERYL CLIFFORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service	16. SOCIAL SECURITY NO. 524-24-9329	17. INFORMANT (Husband) Beltsville, Maryland	Address LeRoy Emard 10405-A. 46th Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1992 DUE TO Generalized Circumstances Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO Carcinoma of the Colon & Cervix (c) DUE TO of the Rectum		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1966 , to Oct. 13, 1966 , that (I) (we) last saw the deceased alive on 9-13 1966 , and that death occurred at 11:45M , from causes and on the date stated above.		22b. DATE SIGNED 10-1466	
22a. SIGNATURE A. Deitz		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Hyattsville Md.
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		23d. LOCATION (City or Town) (County) (State) LaJUNTA, COLORADO	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/17/1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS WASH.D.C. HYSONG'S FUNERAL HOME-1300 N ST, N.W.
24. FUNERAL DIRECTOR HYSONG'S FUNERAL HOME-1300 N ST, N.W.		25a. RECD BY REGISTRAR DATE OCT 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



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FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

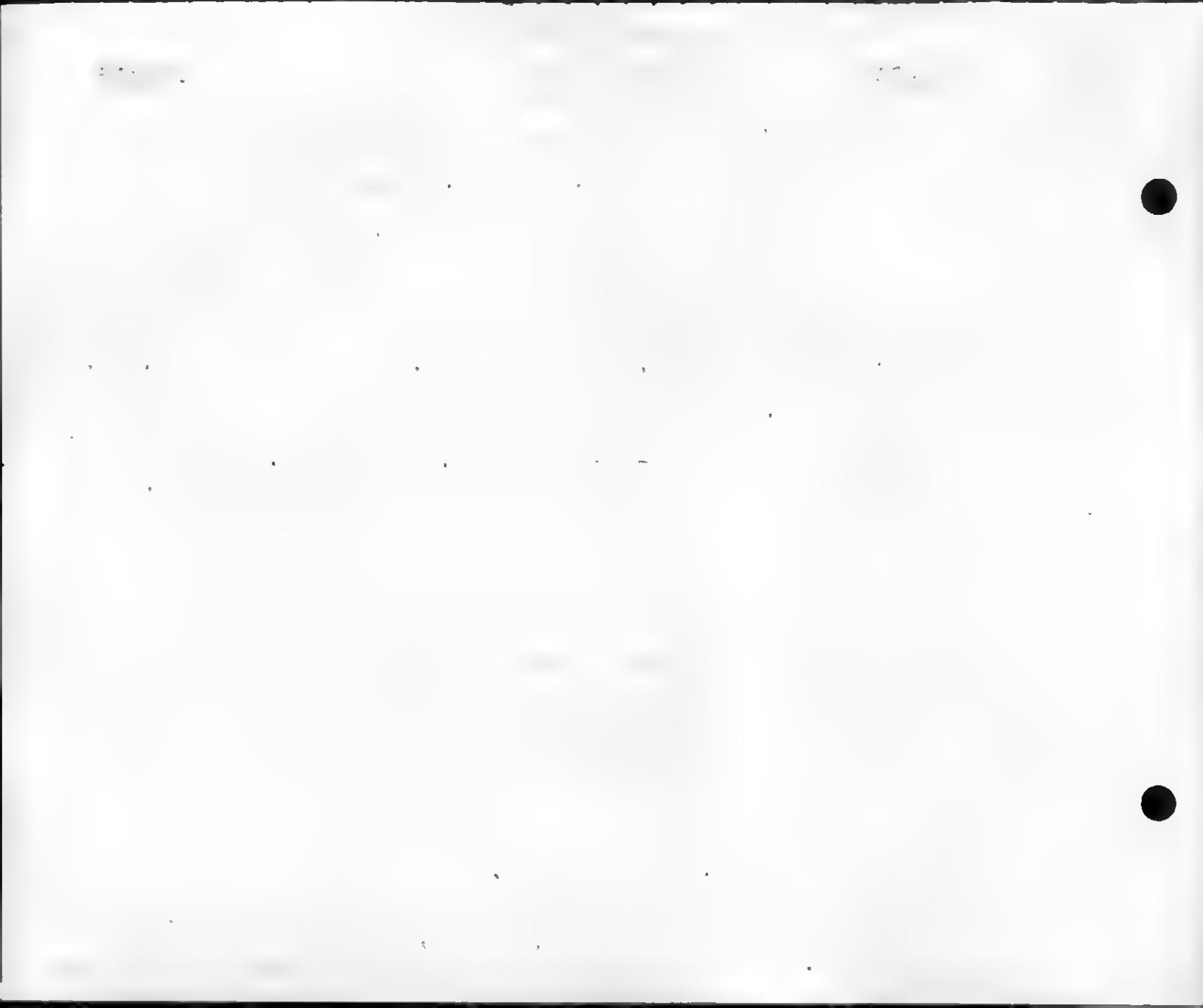
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14562 11563

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 45 min.		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3819 37th. Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Mary	Middle S	Last Fisher
4 DATE OF DEATH	10	Month 29	Day 19
5 SEX	6 COLOR OR RACE Female White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 20 May 1894	9 AGE (In years lost birthday) 72 yrs	10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11 BIRTHPLACE (State or foreign country) Wash., D.C.	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick W. Garress		14. MOTHER'S MAIDEN NAME Mary Walsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-46-2260	
17. INFORMANT Mrs. Catherine F. Hewlett - Taney Dr		Address 13209 - (Daughter) Beltsville, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes	
+ x 10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		unknown	
DUE TO Arteriosclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) Diabetes - known over 2 years		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 10-30-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/2/66	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Home Inc.	Nalley's Funeral ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE NOV 4 1966
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14563

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1924 SANDY SPRING RD		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY Pr. Geo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1924 SANDY SPRING RD		e. STREET ADDRESS 1924 SANDY SPRING RD		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL R.D.		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN FREDERICK FLESTER SR		First	Middle	Last	4. DATE OF DEATH Month October	Year 1966	Month Day Year		
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1879	9. AGE (in years at birthday) 86	10. UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER RET.		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ANDREW FLESTER		14. MOTHER'S MAIDEN NAME MARY AITCHESON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT MRS MARGARET FLESTER	Address Same as D2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500		Lobar Pneumonia, Rt. Lower and middle lobes.						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. (b) DUE TO Generalized Arteriosclerosis.		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1954		20f. (City or town) Laurel		(County) MD	(State) MD
21. I certify that (I) (this hospital) attended the deceased from 1954 , 1966, to 1966 , that (I) (wp) last saw the deceased alive on 1966 and that death occurred at 1966 M, from causes and on the date stated above.									
22a. SIGNATURE <i>Harold S. Wade</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) T. O. J. H. YELD, D.O.		22d. ADDRESS 115 S. LAUREL ST. FT. LAUREL MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL Oct 28, 66		23b. DATE THEREOF Oct 28, 66		23c. NAME OF CEMETERY OR CEMATORIAL IVY HILL CEM		23d. LOCATION (City or Town) Laurel Maryland		(County) MD	(State) MD
24. FUNERAL DIRECTOR Harold S. WADE, LAUREL MARYLAND		ADDRESS 115 S. LAUREL ST. FT. LAUREL MARYLAND		25a. RECD BY REGISTRAR OCT 26 1966		25b. REGISTRAR'S SIGNATURE <i>Harold S. Wade</i>			

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form P-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14564

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14565

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
Prince George's MARYLAND		Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		Mt. Rainier	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 4444 Rainier Avenue	
3. NAME OF DECEASED (Type or print)		First	Middle
Female		Helen	D
4. DATE OF DEATH		Month	Day Year
5. SEX		5. COLOR OR RACE	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER		10b. KIND OF BUSINESS OR INDUSTRY BUREAU U.S.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME EDWARD SAGE		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT CARLTON R. FLICK 6517 PERSIMMON TREE RD, CABIN JOHN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 5120 DUE TO From Mallory - Weiss syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) And Fracture right femur, right tibia and right fibula (c) From Trauma Auto accident		Address INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pedestrian struck by truck	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:15 a.m. 10-5-1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8th. & D. Sts., N.W. Washington, D.C.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-11-66	
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-14-1966	23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 19 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

See Fins 1915-10, 1916.

Mr. Thompson says the date of the
first flight was in N.F.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14565

CERTIFICATE OF DEATH

14567

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>18 HRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>		d. STREET ADDRESS <u>CAMP SPRINGS 8504 Allentown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>EDWIN</u>	First <u>M.</u>	Middle <u></u>	Last <u>FOSTER</u>
4. DATE OF DEATH <u>Oct. 9, 1966</u>	Month <u>Oct.</u>	Day <u>9</u>	Year <u>1966</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-25-1914</u>
9. AGE (In years last birthday) <u>52 yrs.</u>	10. IF UNDER 1 YEAR <u>Months</u>	11. IF UNDER 24 HRS. <u>Days</u>	12. IF UNDER 24 HRS. <u>Hours</u>
10b. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ST. ELIZABETH'S HOSPITAL, KING GEORGE, VA.</u>	
13. FATHER'S NAME <u>Ernest W. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Emilie Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>HW-11</u>	
17. INFORMANT <u>Mrs. Louise E. Foster #2</u>		Address <u>same as</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>CONGESTIVE HEART FAILURE WITH PULMONARY EDEMA</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u></u>		DUE TO <u>ANTERIOR MYOCARDIAL INFARCTION</u> <u>18 HOURS</u>	
DUE TO <u>(c) HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE 3 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour am P.M. <u>None</u>		20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>
20f. (City or town) <u>None</u>		(County) <u>None</u> (State) <u>None</u>	
21. I certify that (I) (his hospital) attended the deceased from <u>SEPT 29, 1966</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>10/9/66</u> , and that death occurred at <u>None</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8808 BRANCH AVE., CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 12-1966</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Washington National</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1966</u>	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14568

CERTIFICATE OF DEATH

14568

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY - - -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Forestville		c. LENGTH OF STAY IN 1b - - -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
3. NAME OF DECEASED (Type or print) MARGUERITE		4. DATE OF DEATH October 13, 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Feb. 11, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. FATHER'S NAME Michael F. Bolger		10d. BIRTHPLACE (County & State, or foreign country) D.C.	
10e. MOTHER'S MAIDEN NAME Cora Langley		10f. CITIZEN OF WHAT COUNTRY? USA	
10g. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv etc) No		10h. SOCIAL SECURITY NO. Margaret Abell-4006 E Cap. Street, DC	
10i. INFORMANT Address		10j. INFORMANT Address	
10k. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition, anemia DUE TO 200 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Myeloma DUE TO (c)		10l. INTERVAL BETWEEN ONSET AND DEATH 2 months	
10m. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		10n. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10o. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		10p. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
10q. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		10r. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	10s. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) 10t. (City or town) (County) (State)
10u. I certify that (I) (this hospital) attended the deceased from 6/24 , 19 66 , to 10/13 , 19 66 , that (I) (we) last saw the deceased alive on 10/13 19 66 , and that death occurred at 520 M , from causes and on the date stated above.		10v. DATE SIGNED 10/13/66	
10w. SIGNATURE Frank J. Fedor		10x. ATTENDING M.D. PHYS. <input type="checkbox"/>	10y. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
10z. PHYSICIAN'S NAME (Type) Frank J. Fedor		10aa. ADDRESS 4201 Cathedral Ave NW DC	
10bb. BURIAL, CREMATION, REMOVAL (Specify) Burial		10cc. DATE THEREOF 10/17/66	10dd. NAME OF CEMETERY OR CREMATORIUM Wash. National
10ee. FUNERAL DIRECTOR Has. T. Ryan, Inc.		10ff. ADDRESS 317 Pa. Ave., SE DC	10gg. LOCATION (City or Town) (County) (State) Suitland, Md.
10hh. RECD BY REGISTRAR Charles Judge		10ii. DATE OCT 17 1966	10jj. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14567

CERTIFICATE OF DEATH

14569

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADELPHI		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELTSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PAINT BRANCH NURSING HOME		d. STREET ADDRESS 11272 EVANS TRAIL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLOTTE	Middle Haddick	Last FULLERTON	4. DATE OF DEATH Oct. 9 1966	Month Oct.	Day 9	Year 1966
5. SEX F	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1880	9. AGE (in years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Haddick		14. MOTHER'S MAIDEN NAME ?		15. INFORMANT Robert Dyas		16. SOCIAL SECURITY NO. 326-30-7243	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. ADDRESS 11272 Evans Trail, Beltsville Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 3-4 days							
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerotic cardiovascular disease 1-2 yrs (c) Cerebral deterioration							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 1964 , 19, to 9 Oct , 1966 that (2) we last saw the deceased alive on 9 Oct , 1966, and that death occurred at 12:45 P.M. from causes and on the date stated above.							
22a. SIGNATURE Ernest E. Harmon		22b. MEDICAL ATTENDING PHYSICIAN M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		DATE SIGNED 9 Oct 66			
22c. PHYSICIAN'S NAME (Type) Ernest E. Harmon		22d. ADDRESS 9301 Colesville Rd., S.S., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 13, 1966		23c. NAME OF CEMETERY OR CEMATORIAL Western Township Cem.		23d. LOCATION (City or Town) (County) (State) Henry County, Illinois	
24. FUNERAL DIRECTOR John B. Thomas		ADDRESS John B. Thomas, 843½ Georgia Ave.		25a. REC'D BY REGISTRAR DATE OCT 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
Warner & Purphrey, Inc.		Silver Spring, Md.					

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

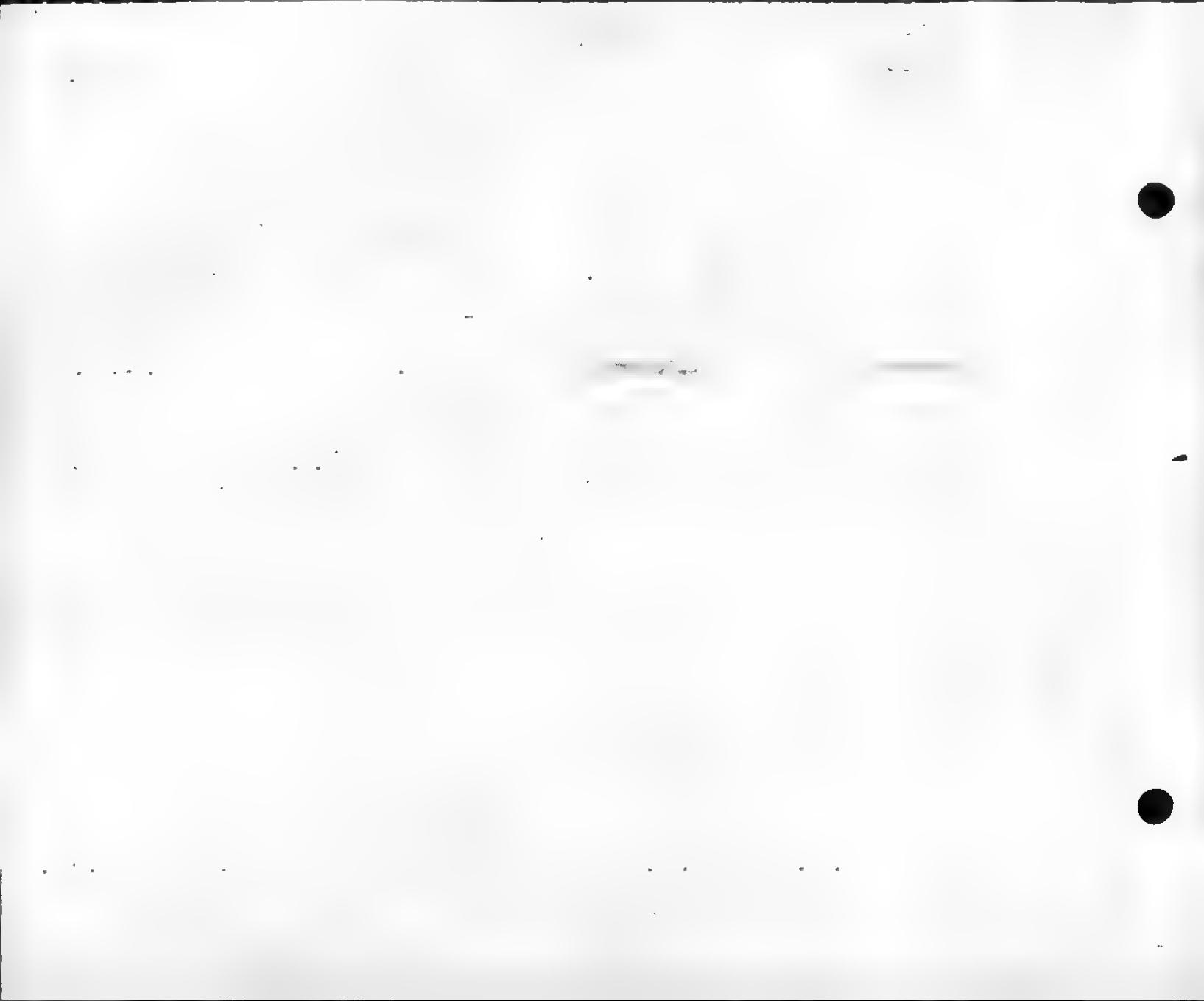
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

14563

CERTIFICATE OF DEATH

14570

1 PLACE OF DEATH a. COUNTY Prince Georges		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		b. COUNTY Prince Georges	
c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 5706 Kennedy Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George W. Goodwin		4. DATE OF DEATH Month October	Day 6, 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		9. DATE OF BIRTH 7-1-95	
10. KIND OF BUSINESS OR INDUSTRY Office		11. BIRTHPLACE (County & State, or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 413 092711	
17. INFORMANT Medical Record/S.C. Winburn/Wife's uncle		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks understand	
Cerebral Hemorrhage General arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1966, to Oct 6, 1966, that (I) (we) last saw the deceased alive on Oct 5, 1966, and that death occurred at 7:55 AM, from causes and on the date stated above.			
22a. SIGNATURE L. W. Malin		22b. DATE SIGNED 11/6/66	
22c. PHYSICIAN'S NAME (Type) L. W. Malin, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-66	23c. NAME OF CEMETERY OR CREMATORIAL St. LINCOLN CEM
23d. LOCATION (City or Town) BLADENSBURG MD		(County) (State)	
24. FUNERAL DIRECTOR W. L. Chambers		ADDRESS Riverdale, MD	
25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14569

CERTIFICATE OF DEATH

16063

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 PLACE OF DEATH o COUNTY Prince George		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b D.O.A.		a. STATE Maryland b. COUNTY Pr. Geo's	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS --		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco <i>1601</i>	
3. NAME OF DECEASED (Type or print) Robert Chalmers		First Robert	Middle Chalmers	Last Goshorn	4. DATE OF DEATH October 26, 1966
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 10, 1881	9. AGE (In years last birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Samuel Goshorn		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO ----		17. INFORMANT James D. Goshorn-Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary occlusion -		DUE TO Emphysema		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Emphysema		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 to Oct. 26 , 1966, that (I) (we) last saw the deceased alive on Oct. 26, 1966 , and that death occurred at 2:11 P.M. from causes and on the date stated above.					
22a. SIGNATURE Robert Chalmers					
22b. DATE SIGNED 10/26/66					
22c. PHYSICIAN'S NAME (Type) Ritchie Brothers		22d. ADDRESS St. Leonard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Immanuel Cemetery		23d. LOCATION (City or Town) (County) (State) Horsehead, Maryland
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 10 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Sc L

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

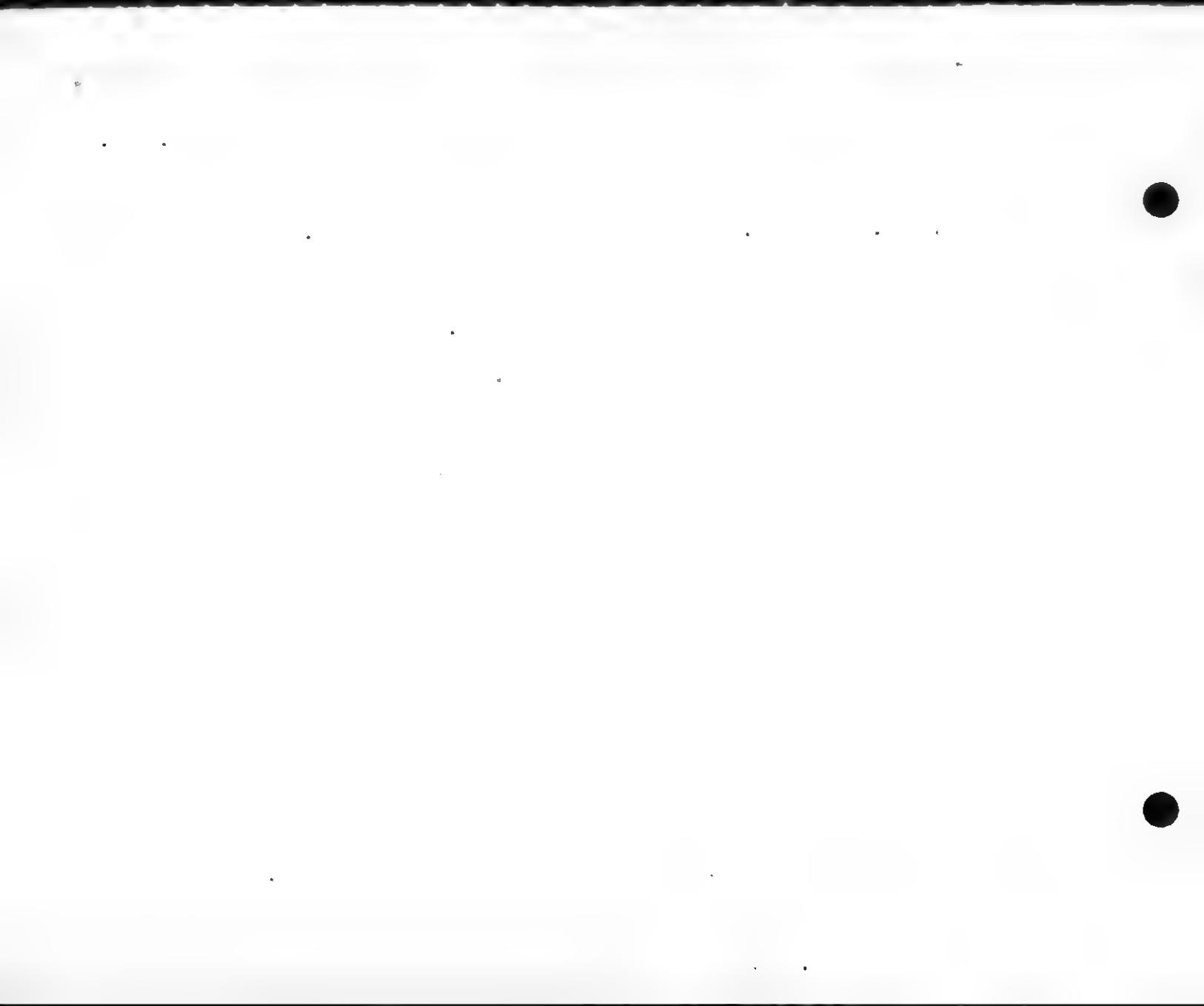
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14571

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4-days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Hgts. (College Park)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.			d. STREET ADDRESS 5914-Natasha Dr.			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Percy	Middle Abner	Last Grant	4. DATE OF DEATH Sept. 27, 1916	Month Oct.	Day 27	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1916	9. AGE (In years from last birthday) 50 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Model Maker			11. BIRTHPLACE (State or foreign country) Goddard Space Agy.			12. CITIZEN OF WHAT COUNTRY? Maine Yes	
13. FATHER'S NAME Abner Grant			14. MOTHER'S MAIDEN NAME Cora			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO 006-09-9858			17. INFORMANT Mary J. Grant (Wife) same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-cerebellar and midbrain infarction INTERVAL BETWEEN ONSET AND DEATH 4 days							
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) Rt. internal carotid artery thrombosis 4 days				
DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 19. WAS AUTOPSY CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 				
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington (County) Virginia (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town, or County) Rivervale			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/66		23c. NAME OF CEMETERY OR Crematory Arlington National		23d. LOCATION (City or Town) Arlington (County) Virginia (State)	
24. FUNERAL DIRECTOR		ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14571 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14572

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Rt. 1, Box 421	
e. FIRST MIDDLE LAST		e. DATE OF DEATH 10 10 19 66	
3. NAME OF DECEASED (Type or print) Lawrence Emory Gray		4. DATE OF DEATH 10 10 19 66	
5. SEX Male Negro WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baborer		8. DATE OF BIRTH 3-1-1903	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) 63 yrs.	
11. BIRTHPLACE (State or foreign country) Prince George's Co. Md.		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME Charles M. Gray		14. MOTHER'S MAIDEN NAME Bertha A. Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFDAMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary occlusion, left anterior descending branch (c) DUE TO Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Riverdale, Md.	
22. DATE SIGNED 10-11-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Peters Church Cem.		23d. LOCATION (City, town or county) (State) Waldorf, Maryland	
24. FUNERAL DIRECTOR Martell Adams Aquasco, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #13 & 14 Film #G-82 10/25/65 pc

14572

CERTIFICATE OF DEATH

14573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 4304 51st Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rowland		First GARCIA	Middle Griffith	4. DATE OF DEATH October 13 1966	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH Dec. 16, 1898	9. AGE (in years last birthday) 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD		10b. KIND OF BUSINESS OR INDUSTRY G.S.A. U.S.		11. BIRTHPLACE (County & State, or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John WILIAM M. GRIFFITH.		14. MOTHER'S MAIDEN NAME UNKNOWN// Melissa Walcott Griffith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 219-34-7925		17. INFORMANT MARY LOIS GRIFFITH Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> INTERVAL BETWEEN ONSET AND DEATH 10-1-66 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> 10-1-66 DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CREMATION</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>10-13-1966</u> , that (I) (we) last saw the deceased alive on <u>10-13-1966</u> , and that death occurred at <u>9:20P</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Albert Roth, M.D.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-18-1966		
22c. PHYSICIAN'S NAME (Type) Albert Roth, M.D.		22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-18-1966	23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA.	
24. FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md.		ADDRESS	25a. REC'D BY REGISTRAR OCT 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-train permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

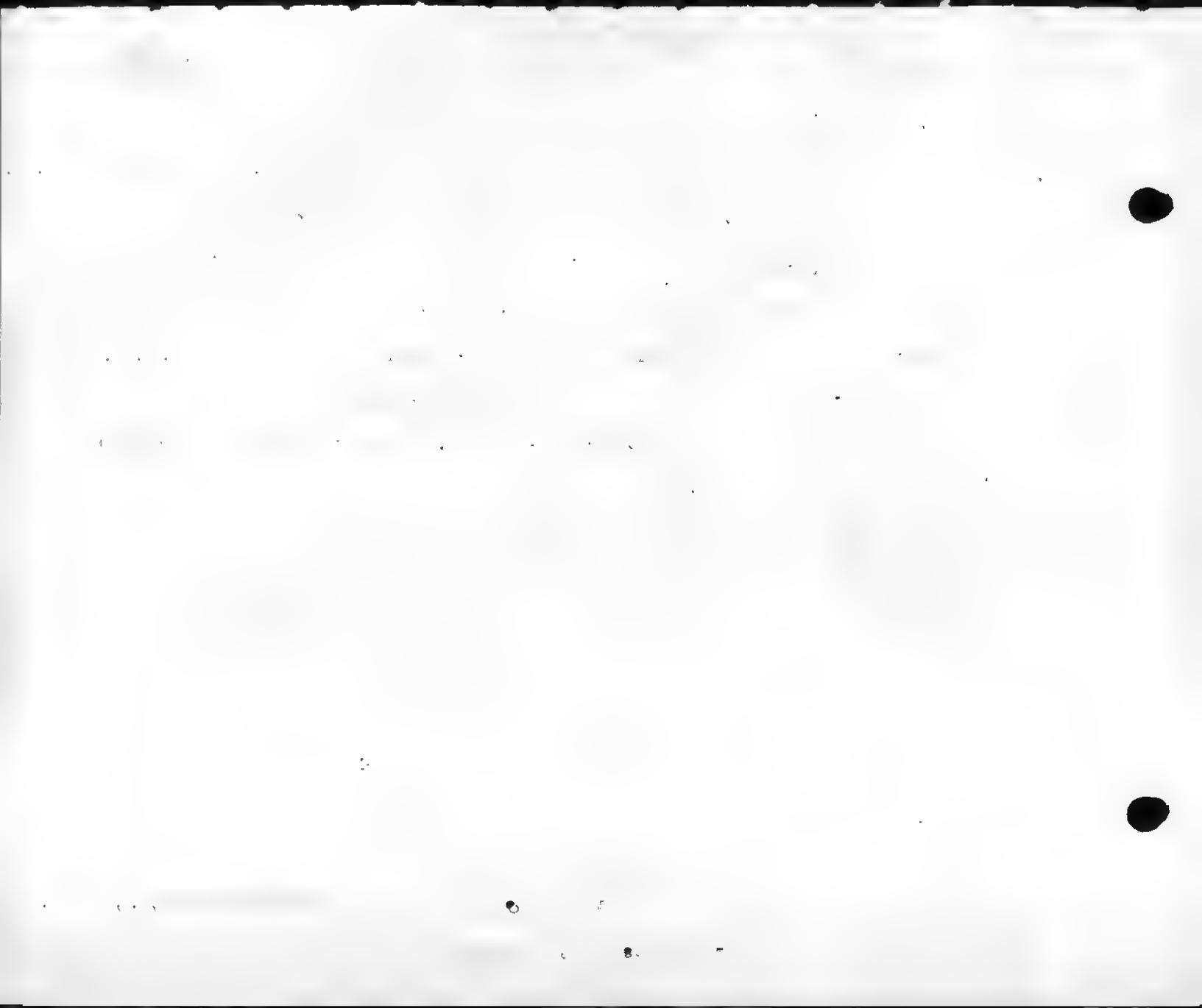
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14574

1. PLACE OF DEATH a. COUNTY <i>Pr. Georges</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Mo</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rogers Heights</i>		c. LENGTH OF STAY IN 1b MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>5624 Elbenton Place</i>		d. STREET ADDRESS <i>5624 Elbenton Place</i>				
3. NAME OF DECEASED First JOSEPH		Middle SCOTT	4. DATE OF DEATH Last Hartley Oct 22 1966			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1912			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Building				
13. FATHER'S NAME Lewis Hartley		14. MOTHER'S MAIDEN NAME Cally Hash				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214 03 0267				
17. INFORMANT Mary W. Hartley Same as #2 (wife)		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Coronary decubitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> 1 day						
DUE TO (b) <i>Coronary Thrombosis</i> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. P.M. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 402 MAIN ST.	20f. (City or town) <i>Hartford</i>	(County) <i>County</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>10/1</i> , 1965, to <i>10/22</i> , 1966, that (I) (we) last saw the deceased alive on <i>10/12</i> , 1966, and that death occurred at <i>9A</i> M, from the causes and on the date stated above.				22b. DATE SIGNED <i>Charles Judge</i>		
22a. SIGNATURE <i>Robert S. McCleary</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Charles Judge</i>		
22c. PHYSICIAN'S NAME (Type) ROBERT S. MCCLEARY, M.D.		22d. ADDRESS 402 MAIN ST.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORIAL BelAir Memorial Park	23d. LOCATION (City, town or county) Hartford County, Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Maryland	25a. REC'D BY REGISTRAR DATE OCT 24 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



1 M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14574

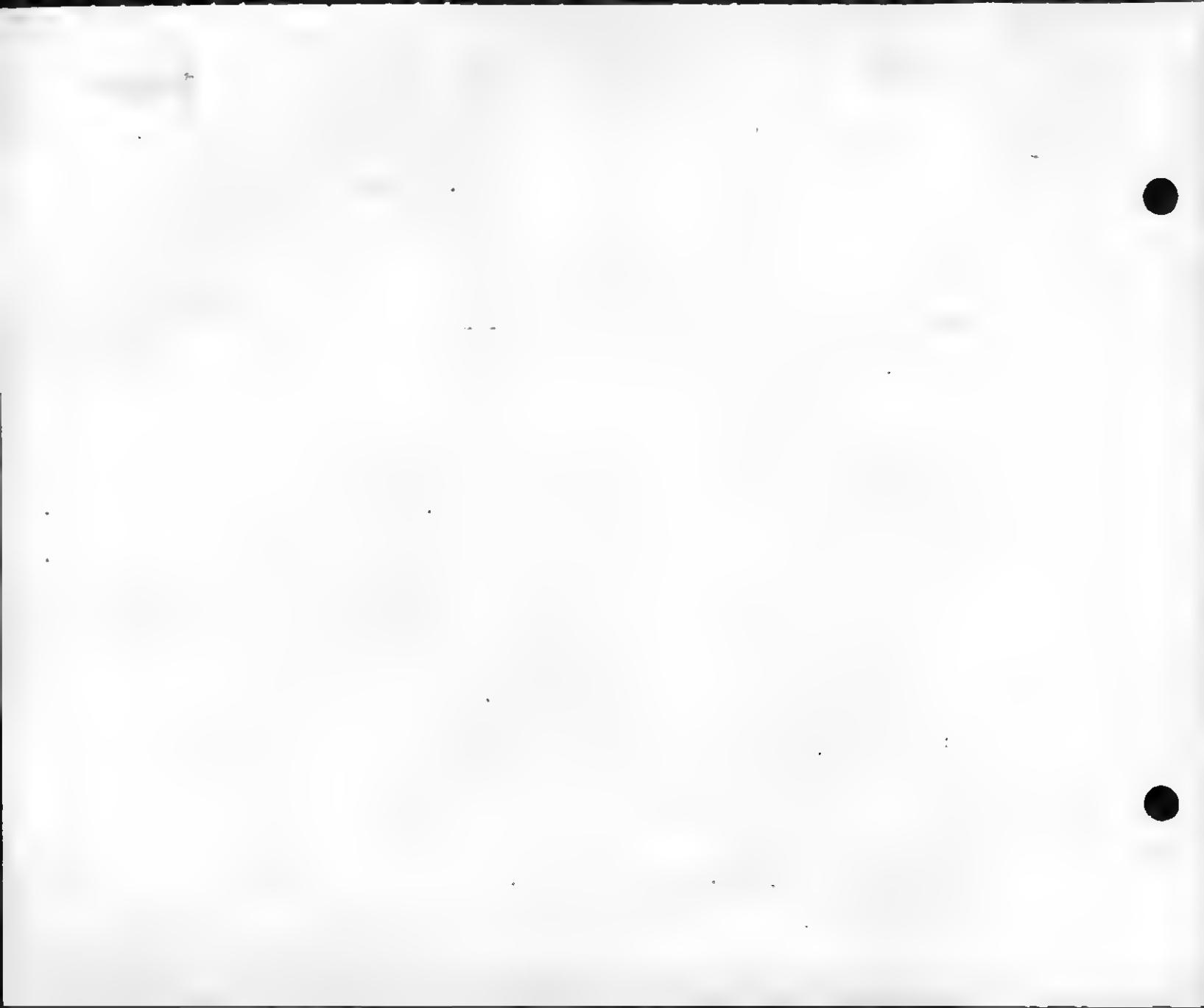
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14575

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 8 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3200 Varnum Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Doris	Middle Ann	Last Hartman
4 DATE OF DEATH 10 27 1966	Month	Day	Year
5 SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
9. AGE (In years last birthday) 20 yrs	10. DATE OF BIRTH 10-2-1916	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.
10a. SOC. OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME THEODORE R. HARTMAN SR		14. MOTHER'S MAIDEN NAME ELLSIE E. GRIGSBY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOC. SEC. NO NONE	
17. INFORMANT THEODORE R. HARTMAN SR		Address 3200 Varnum St. Mt. Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) DUE TO c) DUE TO		Subdural hemorrhage - rt. frontal parietal area 8 hrs.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
20. MEDICAL CERTIFICATION Cerebral palsy 20 years		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fell in bathroom.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Fell in bathroom.	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. 8:00AM 10-27-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Same as 2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-28-66	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) WASHINGTON D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS W.W. Chambers Co. RIVERDALE, MD		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR W.W. Chambers Co.		25a. RECEIVED BY REGISTRAR DATE NOV 2 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, during any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

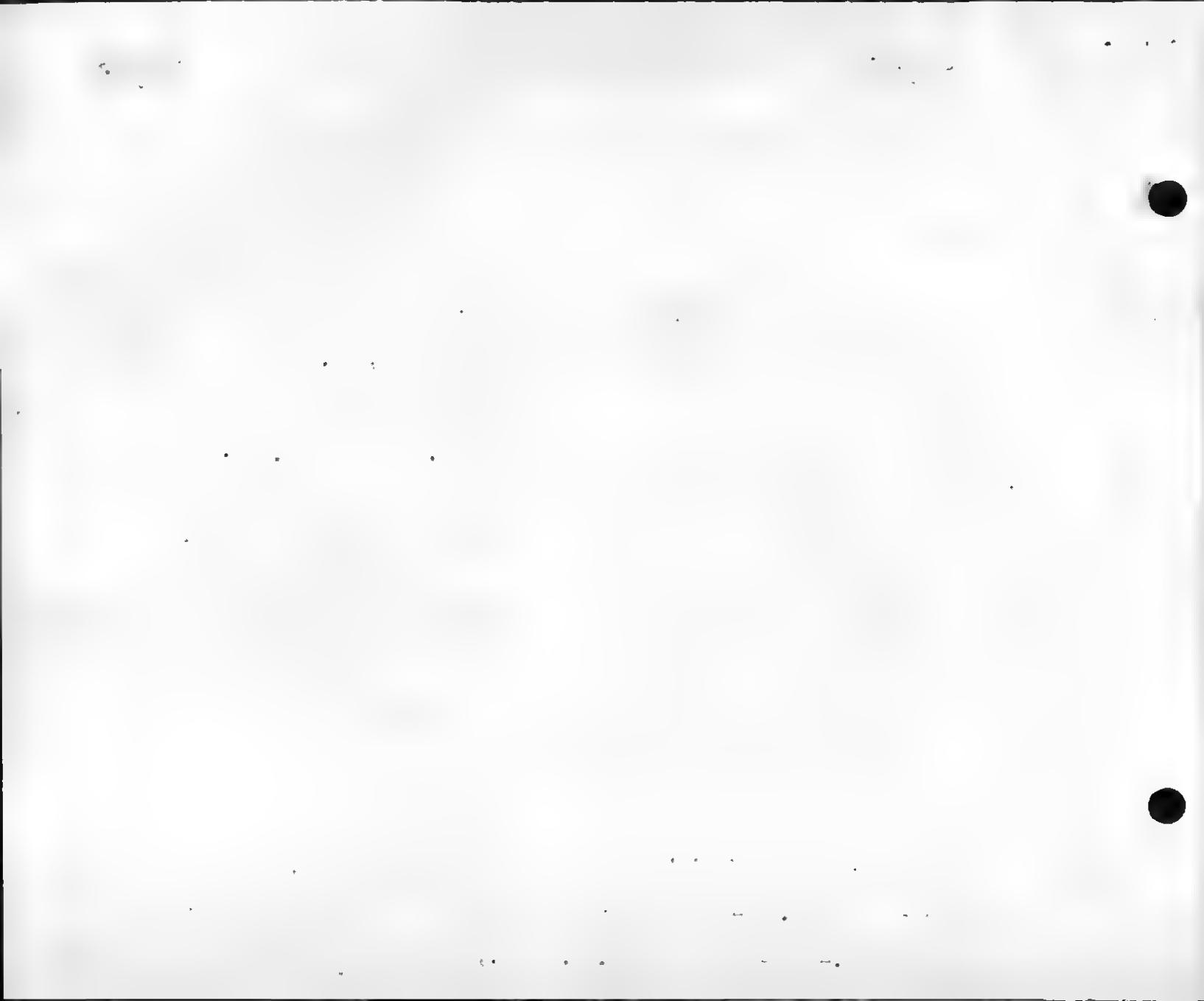
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14575 14576

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 6113 Clearfield Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emma	Middle Katherine	Last Hayes
4. DATE OF DEATH	Month October	Day 20	Year 1966
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Joy		14. MOTHER'S MAIDEN NAME Emma Bartlett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Evelyn G. Hayes (Dau.) Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs	
(b) Arteriosclerotic heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus over 10 years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, town or county) Briarcliff, Md. or county	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 22-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros. - 1661 - Good Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR DATE OCT 24 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14576

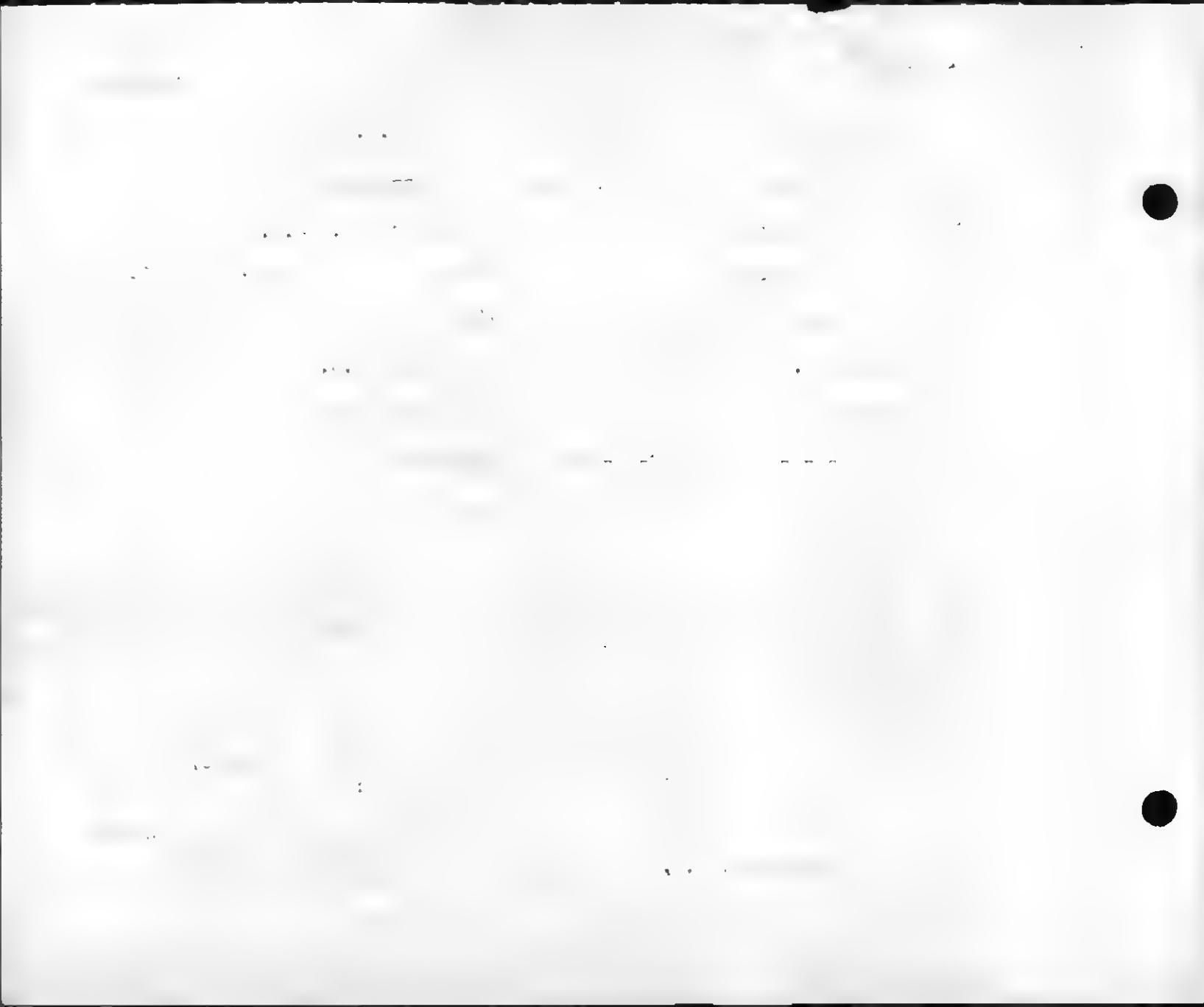
CERTIFICATE OF DEATH

14577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 8 mos 5 days	
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) Henry		d. STREET ADDRESS 811 51st St., N.E.	
3. NAME OF DECEASED (Type or print) Henry		4. DATE OF DEATH October 13, 1966	Month Day Year
5. SEX male	6. COLOR OR RACE negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 12/28/1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Parking Attend.		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME William Hayes		11. BIRTHPLACE (County & State, or foreign country) Raleigh, N.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578-07-2138	
17. INFORMANT Decedent		18. MOTHER'S MAIDEN NAME Ida Williams	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ADDRESS	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Volvulus, small intestine		21. INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) Peritoneal adhesions		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial aspiration of gastric contents; diabetes mellitus; diverticulosis; chronic urinary tract infection		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 2/11, 1966 to 10/13, 1966 , that (we) lost saw the deceased alive on 10/13/ 1966 , and that death occurred at 9:00AM , from causes and on the date stated above.		22b. DATE SIGNED 10/13/66	
22a. SIGNATURE <i>Moe Weiss</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR STAFF PHYS <input type="checkbox"/>	22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Harmony Memorial Park Maryland
24. FUNERAL DIRECTOR Stewart Funeral Home		25a. ADDRESS <i>John Stewart Foot-Banning</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
25a. REC'D BY REGISTRAR DATE OCT 18 1966		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14578

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH o COUNTY Prince George		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 4708 Banner Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4708 Banner Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) EDWIN		First	Middle	Last	4. DATE OF DEATH OCT. 11, 1966	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1870	9. AGE (In years at birthday) 96 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpet Layer		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (County & State, or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM HEHR				14. MOTHER'S MAIDEN NAME MARY HEEB				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Marie F. Heyn		4708 Banner Street Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 6 hrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Colmar Manor		(County) P.G. (State) Md.
21. I certify that (I) (this hospital) attended the deceased from 4/28/66 to 10/14/66, that (I) (we) last saw the deceased alive on 10/10/66, and that death occurred at 435 M, from causes and on the date stated above.								
22a. SIGNATURE F. E. Müsser, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/11/66		
22c. PHYSICIAN'S NAME (Type) F. E. Müsser, M.D.		22d. ADDRESS 4410 74th Ave Hyattsville						
23a. BURIAL, CREMATION, BURIAL (Type)		23b. DATE THEREOF 10/13/66		23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN		23d. LOCATION (City or Town) Colmar Manor		(County) P.G. (State) Md.
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

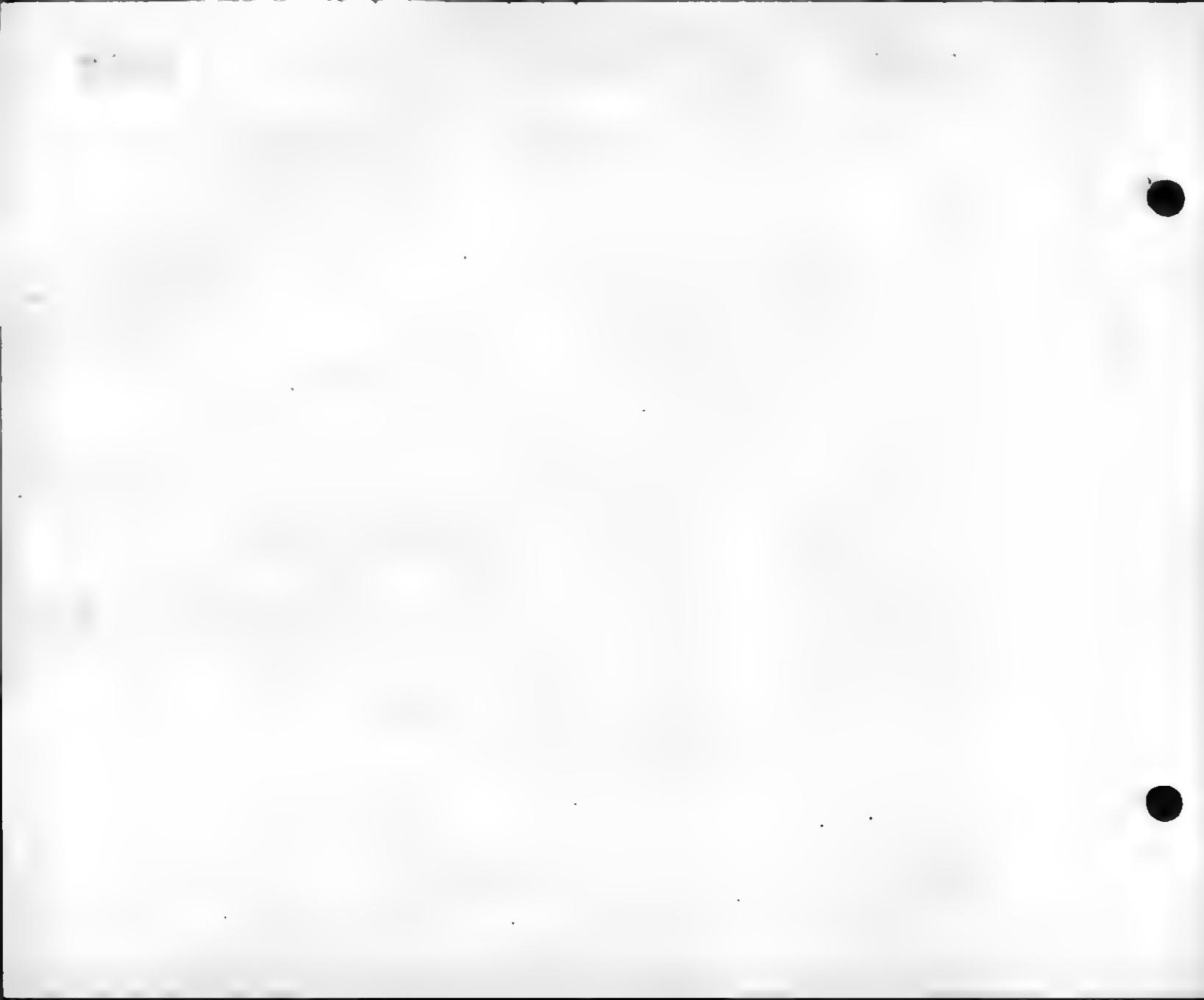
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14578

14579

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Prince George MARYLAND		Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
near Upper Marlboro		Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Rt 301		RT 1 Bay 429	
3. NAME OF DECEASED (Type or print)		First	Middle
Bernard F. Heilig			
4. DATE OF DEATH		Month	Day
		October	4
		Year	1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
July 19 1894		72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Farmer		Maryland	
12. CITIZEN OF WHAT COUNTRY		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Fabian Heilig		Theresa Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		218-03-7093	
17. INFORMANT		Address	
Mrs Bernard Heilig		Bowie Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Minutes	
4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Severe Coronary Arteriosclerosis	
DUE TO (b)		Years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM
Burial		10/8/66	Bowie Cemetery
24. FUNERAL DIRECTOR		ADDRESS	25a. RECD BY REGISTRAR
McNeil Funeral Home Laurel Md.			25b. REGISTRAR'S SIGNATURE
			Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

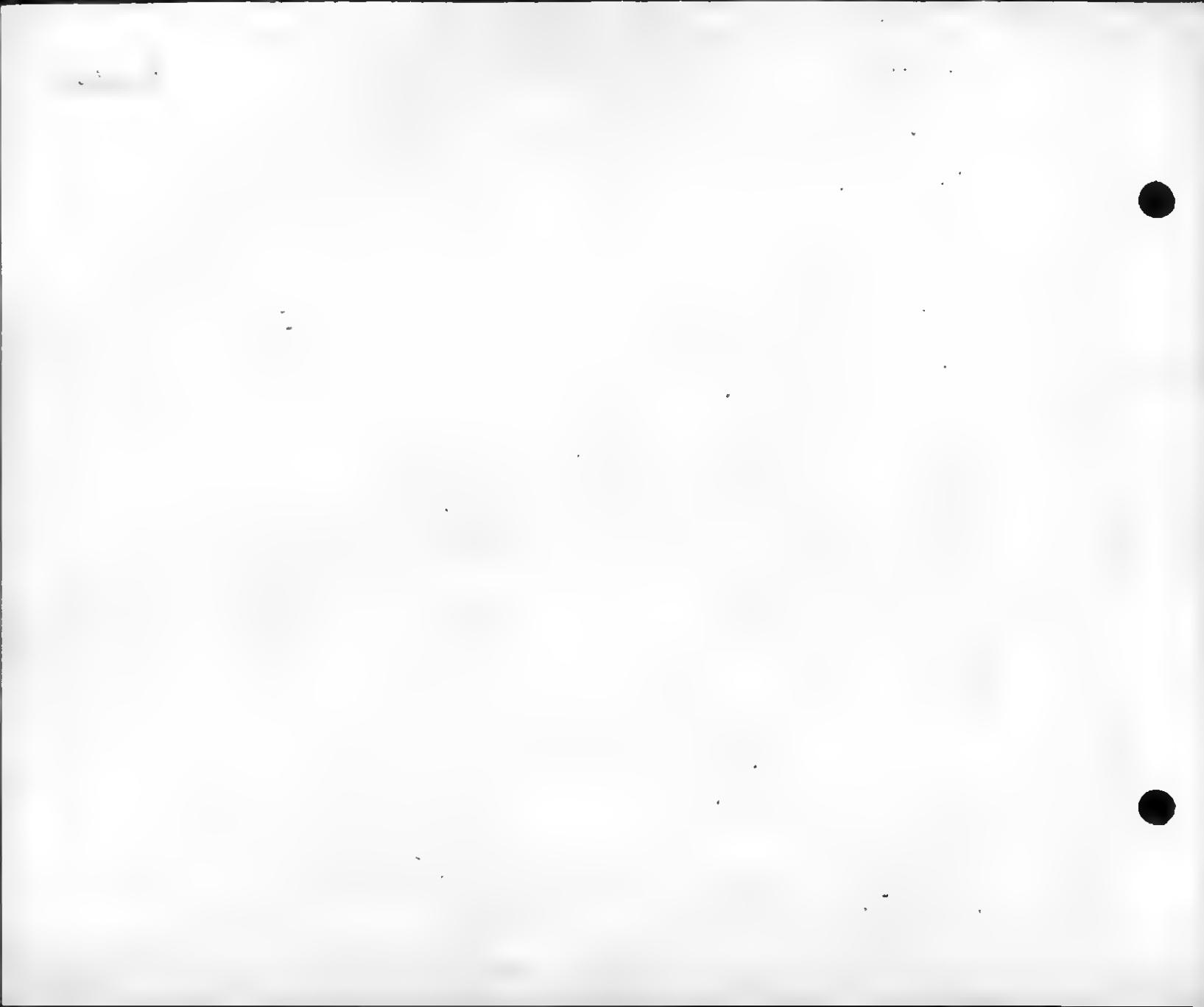
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. The funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

14579

14588

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Forestville</i>		c. LENGTH OF STAY IN TB <i>5 mo</i>		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>The Regent</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash., DC.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALBERT</i>		First	Middle	Last	4. DATE OF DEATH Month <i>OCT</i> Day <i>3</i> Year <i>1966</i>
S. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>SEPT. 1, 1888</i>	9. AGE (In years last birthday) <i>78</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>ST. MARYS-CO. Md.</i>	
13. FATHER'S NAME <i>Melvin H. Herriman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lyon</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>579-01-5941</i>		17. INFORMANT Address <i>Anna May Herriman Same as # 2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 DAYS</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) <i>Essential Hypertension</i>	10 yrs		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>4204</i>	(County) (State) <i>WASH DC</i>
21. I certify that (I) (this hospital) attended the deceased from <i>August 1966</i> to <i>Oct 3, 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct 2, 1966</i> , and that death occurred at <i>4:20 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>William T. Saccardi</i>		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>10/3/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>William T. SACCARDI</i>		22d. ADDRESS <i>1150 Conn Ave NW WASH DC</i>			
23a. BURIAL, CREMATION, REMOVAL (Check) <i>Burial</i>		23b. DATE THEREOF <i>10-6-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Christ Episcopal</i>	23d. LOCATION (City or Town) <i>Chaptico, Md</i>	(County) (State)
24. FUNERAL DIRECTOR <i>Robert H. Mattingly</i>		ADDRESS <i>131-118 S. E. Wed. St.</i>	25a. RECD BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE	
VR A15 (4) 20 M 1/66		DATE <i>OCT 6 1966</i>			



Item 18 Film 387 4-13-6 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1
 FOR STATE
 HEALTH DEPT.

14580

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14581

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake 16 hrs		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 9702 48th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louisa Middle K		Last H. C. R. 200	
4. DATE OF DEATH October 2 19 66		Month Day Year	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1886	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Binder		11b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Washington D C		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Margaret Dwyer College Park, Md.	
17. INFIRMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Electrolyte imbalance Intestinal obstruction (Cause undetermined)			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (Cause undetermined)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> ; Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O. Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O. Watkins		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) 14-3			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 5, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) Arlington National Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE OCT 6 1966		25b. REGISTRAR'S SIGNATURE Harley Judge	

5318 April 12 1971
Euler, L. C., 1805-1855.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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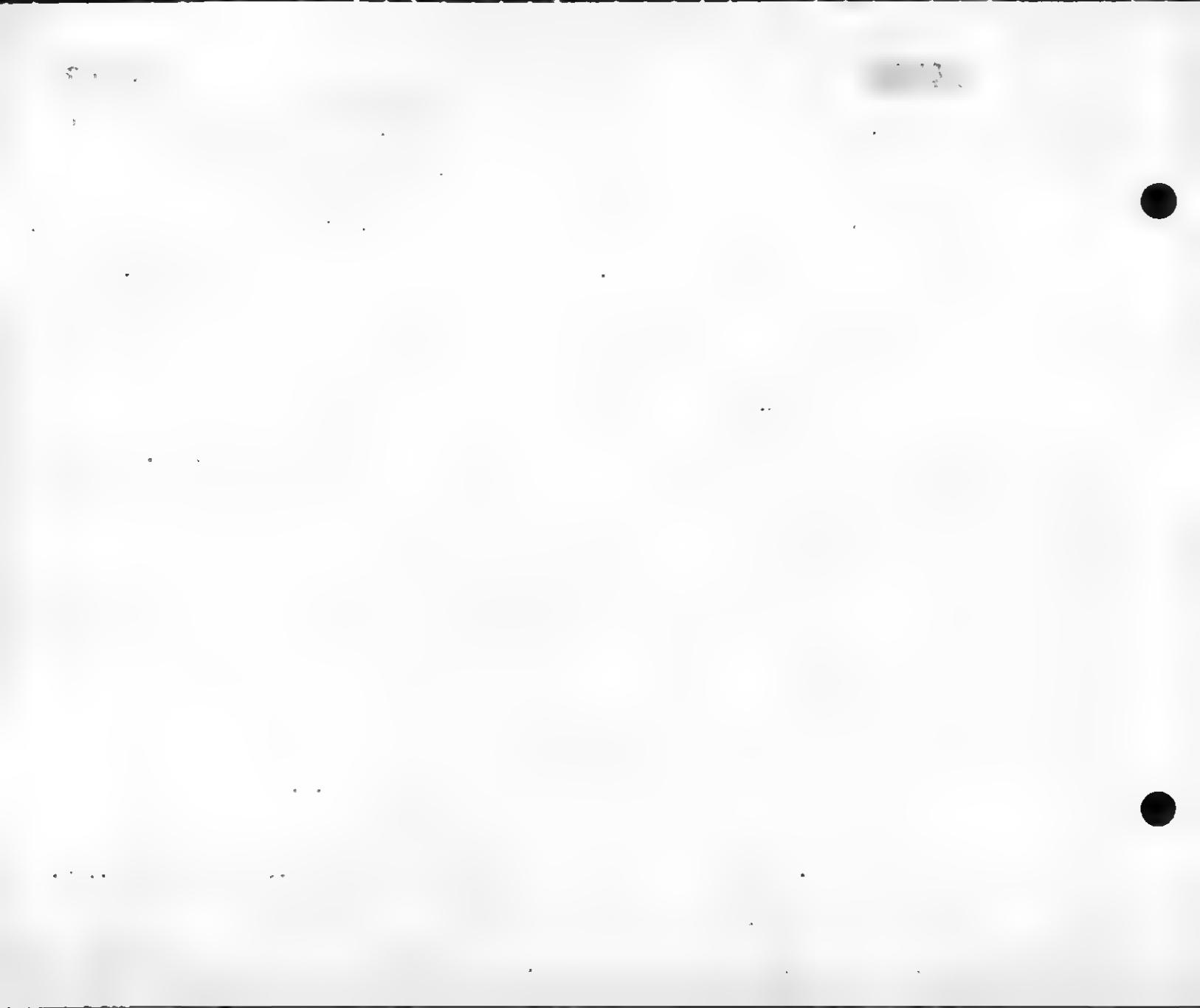
CERTIFICATE OF DEATH

14582

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7214 Hawthorne Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle E.	Last Hill
4. DATE OF DEATH October 31, 1966	Month Year	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 8/8/1890	9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME George Dolan		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Terminal INTERVAL BETWEEN ONSET AND DEATH 7200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 to 10/31/66 , that (I) (we) last saw the deceased alive on 10/30/66 , and that death occurred at 10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED 10/31/66	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Ave., Capital Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 3, 1966	23c. NAME OF CEMETERY OR Crematory Arlington National
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE NOV 7 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

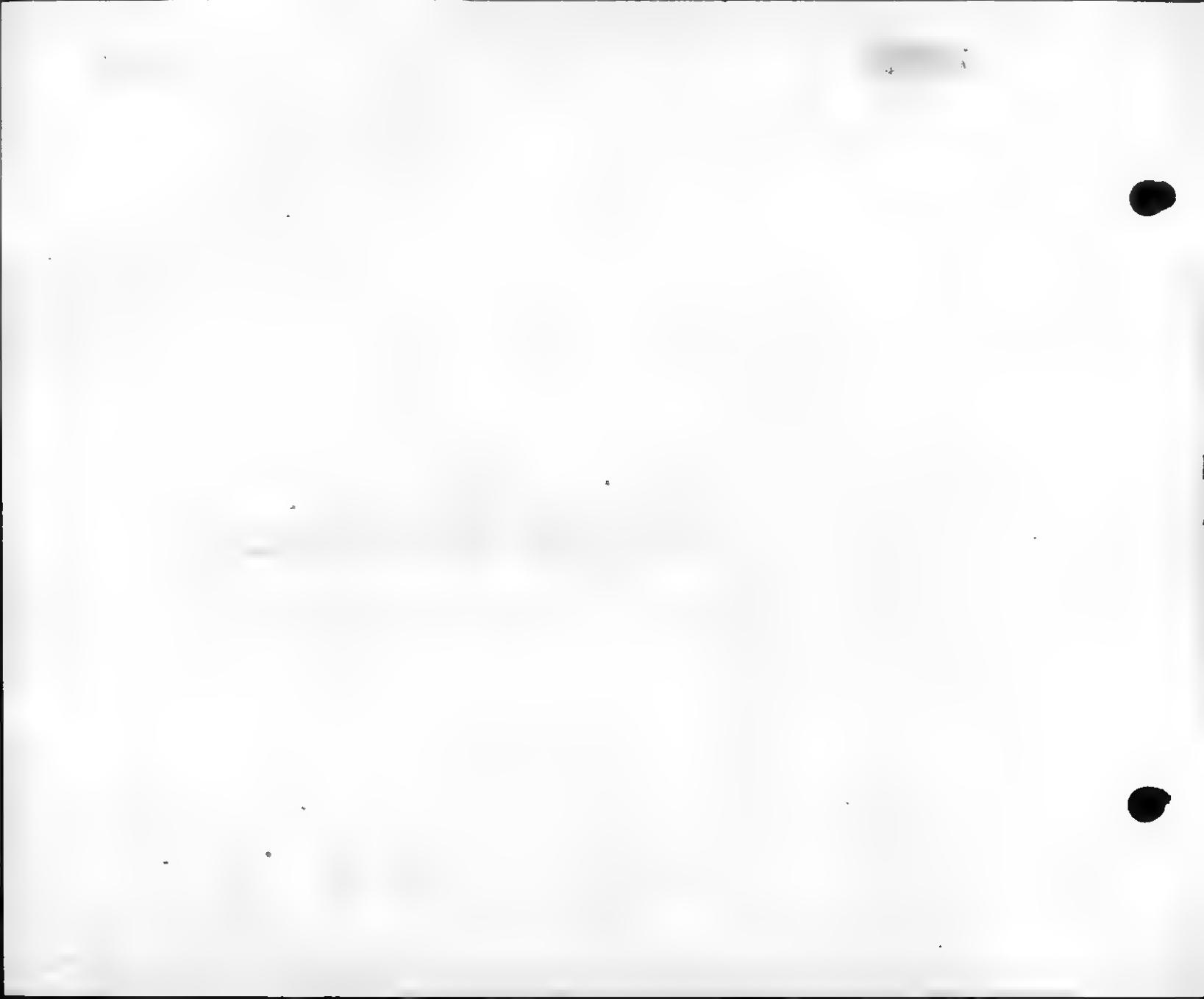
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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14582

CERTIFICATE OF DEATH

14583

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>VA</i> b. COUNTY <i>WARREN</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> 3 hrs c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Front Royal</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3713 Kennedy Street</i>		d. STREET ADDRESS <i>Rivermont Drive</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JAMES</i>	Middle <i>RALPH</i>	Last <i>Hill</i> 4. DATE OF DEATH Month <i>Oct</i> Day <i>8</i> Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10/1900</i> 9. AGE (In years last birthday) <i>66</i> yrs. 10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C. Transit</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. <i>578-10-6680</i>	17. INFORMANT <i>FRANCES L. Hill</i> , Address <i>Rivermont Drive, Front Royal, VA</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4000</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac failure</i> <i>Anterior Myocardic heart disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/10</i> , 1966, to <i>10/18</i> , 1966, that (I) (we) last saw the deceased alive on <i>10/16</i> 1966, and that death occurred <i>10/18</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Hilbert S. Sabin</i> 22b. DATE SIGNED <i>10/18/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Hilbert S. Sabin</i>		22d. ADDRESS <i>1712 Eye St. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 10/11/66</i>		23b. DATE THEREOF <i>10/11/66</i> 23c. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town or county) (State) <i>BUCK VALLEY METHOD. CEM. WARFORDSBURG, PA.</i>	
24. FUNERAL DIRECTOR <i>W.W. Chambers Co. Rivermont, MD</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 13 1966</i> 25b. REGISTRAR'S SIGNATURE <i>James S. Judge</i>	



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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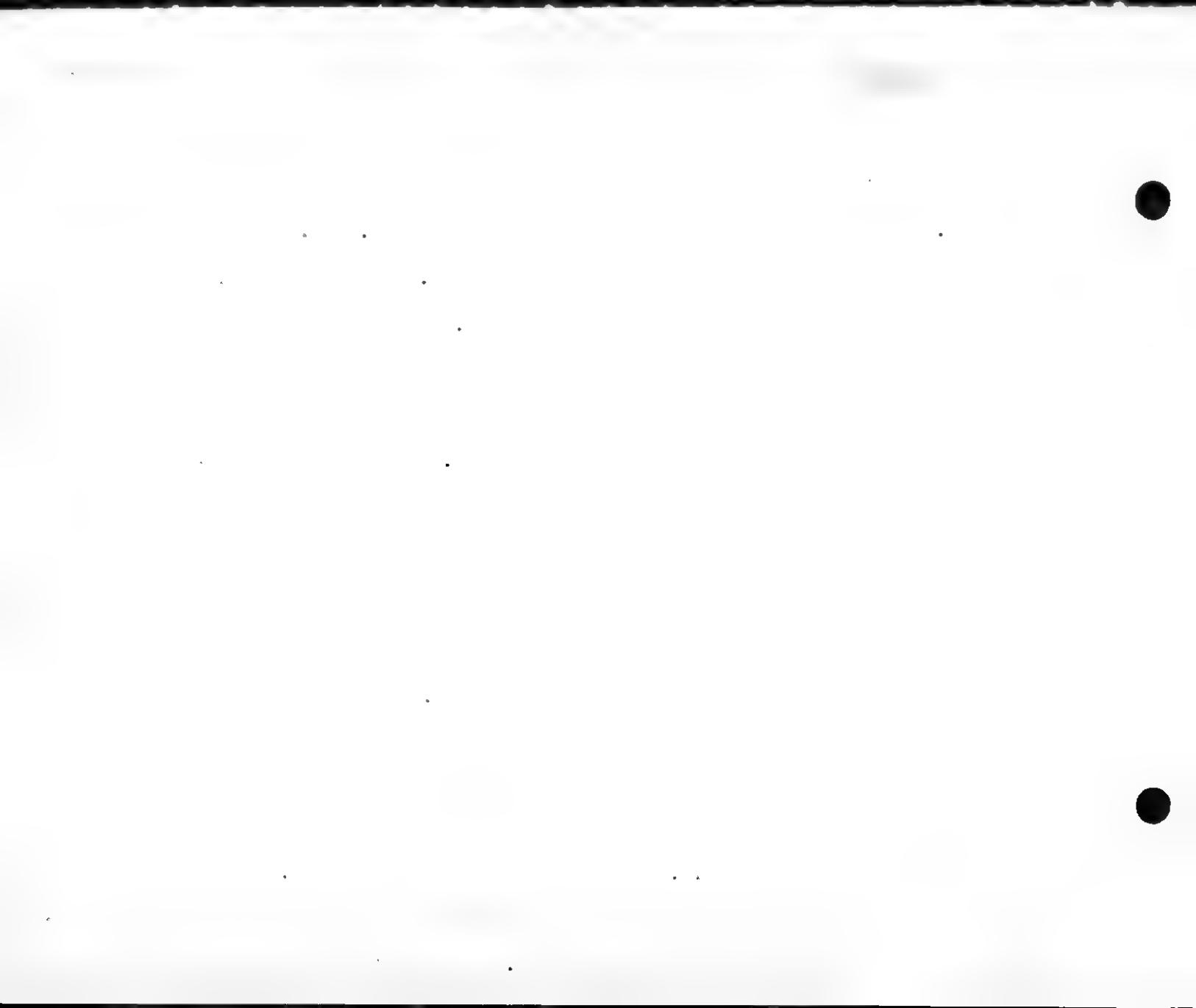
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14584

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 4-hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		e. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Villa Hgts. (Bladensburg)	
3. NAME OF DECEASED (Type or print) Richard		First L	Middle Hilton Sr.
4. DATE OF DEATH Oct. 28 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 12, 1906	9. AGE (In years last birthday) 60 yrs	FUNDER 1 YEAR Months 12	IF UNDER 24 HRS Days CTZN OF WHAT COUNTRY? Yes
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		11. BIRTHPLACE (State or foreign country) New York	
12. FATHER'S NAME Hilton		14. MOTHER'S MAIDEN NAME Mabel Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 577 03 1152		16. SOCIAL SECURITY NO 17. INFORMANT Mary T. Hilton (Wife) same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Burns - 50% of body surface		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
1166 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) DUE TO c) DUE TO			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Burned in house fire.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Burned in house fire.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:56 PM 10-27-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Home same as in 2		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town or County) Rivardale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 31, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. RECEIVED BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE OCT 31 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

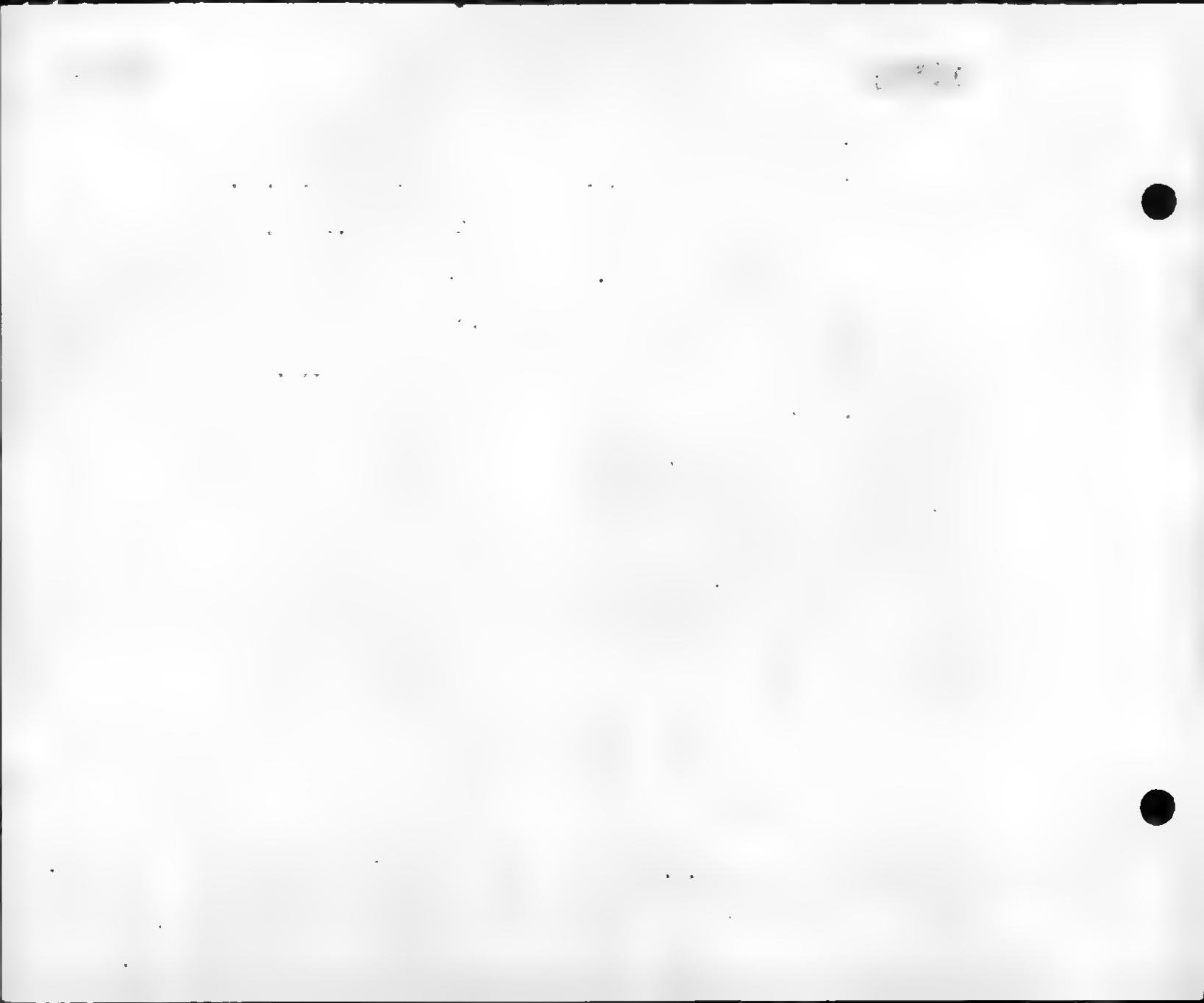
14584

CERTIFICATE OF DEATH

14585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c LENGTH OF STAY IN 1b 1 mo. 27 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. STREET ADDRESS 221 33rd St., N.E.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Solomon A. Holmes		First A.	Middle Holmes
4. DATE OF DEATH October 6, 1966	Month	Day	Year
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 12/6/1910		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Solomon A. Holmes		14. MOTHER'S MAIDEN NAME Catherine Greenleaf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 579-12-5719	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO Chronic renal disease with insufficiency, (c) etiology undetermined		2 yr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic alcoholism with Laennec's cirrhosis of liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/10/66 to 10/6/1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/6/1966 , and that death occurred at 6:40 PM , from causes and on the date stated above.		22b. DATE SIGNED 10/6/66	
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
		23b. DATE THEREOF 10-10-66	23c. NAME OF CEMETERY OR CREMATORIAL LINCOLN CEMETERY SUITLAND MARYLAND
24. FUNERAL DIRECTOR <i>Marshall F. Foy</i>		ADDRESS 414-15th St., S.E.	25a. REC'D BY REGISTRAR OCT 11 1966
			25b. REGISTRAR'S SIGNATURE <i>Clarinda J. Judge</i>



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

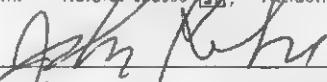
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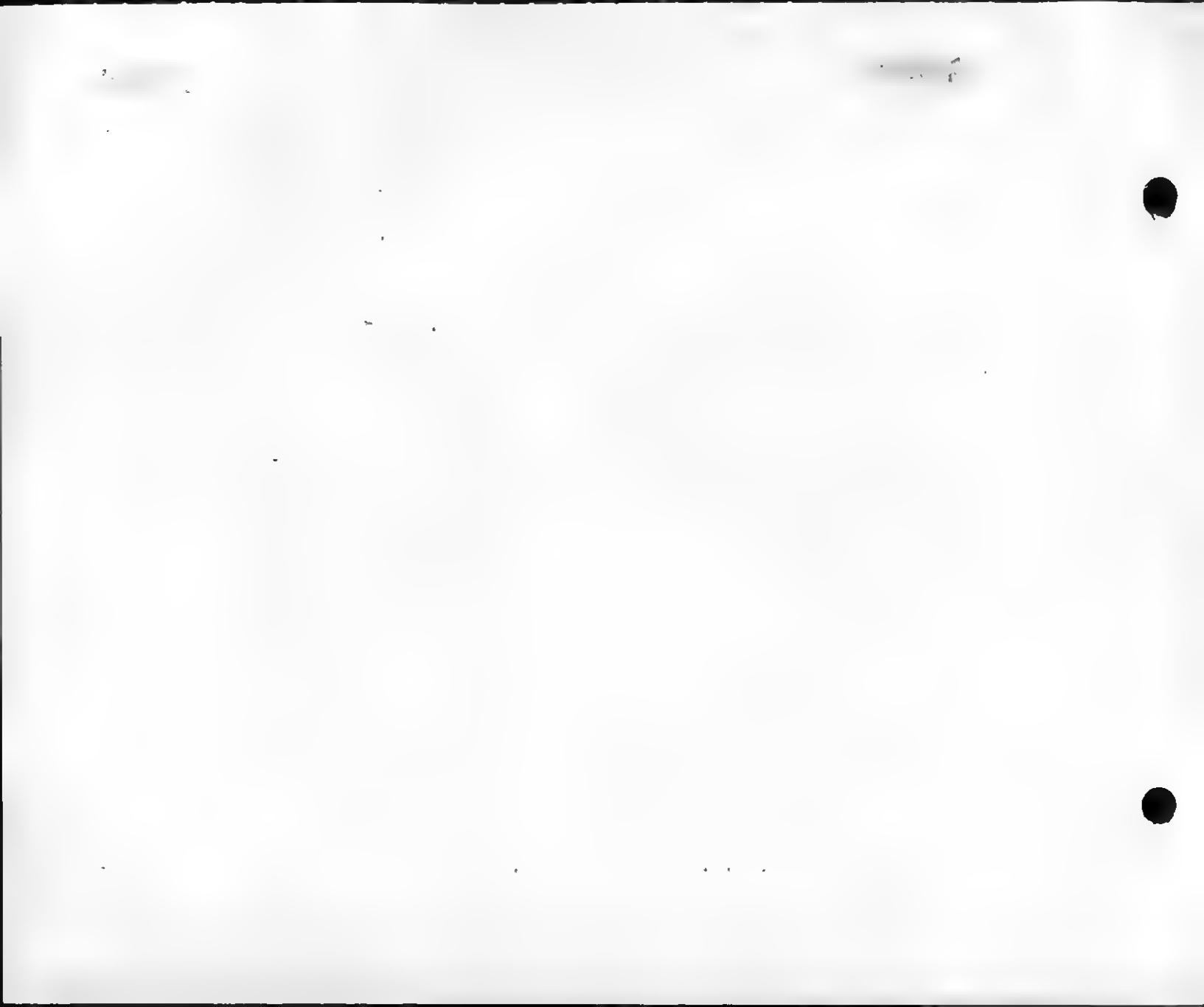
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14586

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			b. COUNTY Prince George's		
c. LENGTH OF STAY IN 1b 13 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital			d. STREET ADDRESS 6205 54th Place		
3 NAME OF DECEASED (Type or print) Viola BEATRICE Hooker			4 DATE OF DEATH Month Day Year 10 23 1966		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B DATE OF BIRTH 29 Dec. 1883	9 AGE (In years last birthday) 82 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER			10b KIND OF BUSINESS OR INDUSTRY U.S. GOVT.		
11 BIRTHPLACE (State or foreign country) WASHINGTON, D.C.			12 CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME LEWIS UNKNOWN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No			16. SOCIAL SECURITY NO NONE		
17. INFORMANT MRS EVELYN PEEBIN			Address 5402 QUINTANA ST. RIVERDALE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bacterial endocarditis INTERVAL BETWEEN ONSET AND DEATH unknown					
t300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 10-24-66	
23a BURIAL, Cremation, REMOVAL (Specify) BURIAL		23b DATE THEREOF 26 Oct 1966	23c NAME OF CEMETERY OR CREMATORIAL ADDRESS ARLINGTON NATIONAL	23d LOCATION (City or Town) ARLINGTON, VIRGINIA	(County) (State)
24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.		ADDRESS	25a REC'D BY REGISTRAR Charles J. Chambers	25b REGISTRAR'S SIGNATURE Charles J. Chambers	DATE OCT 26 1966



1
FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

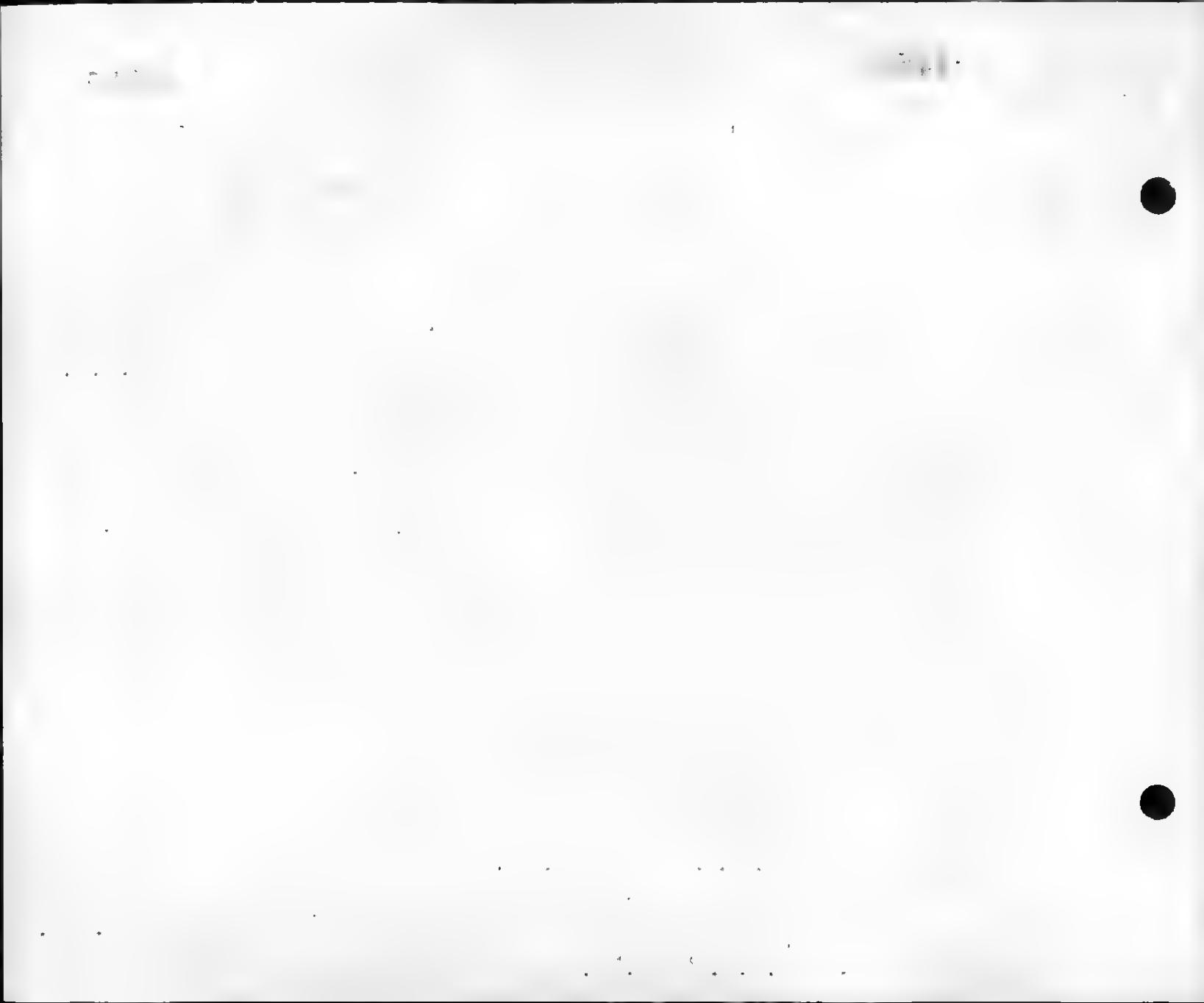
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in my agent within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #14 & 17 File #1387 2/22/67 pg. 14586

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14587

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) College Park				
d. NAME OF HOSPITAL OR INST. T.T. ON (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7505 Citadel Drive				
3. NAME OF DECEASED (Type or print) Liang		4. DATE OF DEATH Hsu 10 23 19 66	Month Day Year			
5. SEX Male		6. COLOR OR RACE White				
7. MARRIED WIDOWED		8. DATE OF BIRTH 11 Dec. 1911				
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		11. BIRTHPLACE (State or foreign country) Library of Congress / China				
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Cheng Hsin Hsu		14. MOTHER'S MAIDEN NAME Unknown / Tu-lan Chen Hsu				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Florence P.C. Address Florence C. Hsu - Same as Item #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.				
DUE TO Hypertensive arteriosclerotic heart disease						
DUE TO						
DUE TO						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-24-66				
ACTUAL SIGNATURE  MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-1966	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery	23d. LOCATION (City or Town) Prince Georges Co. Md.	(County)	(State)
24. FUNERAL DIRECTOR Joseph Gowler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE	
VR A15ME (5) 6M 1/66		DATE OCT 27 1966				



MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14587

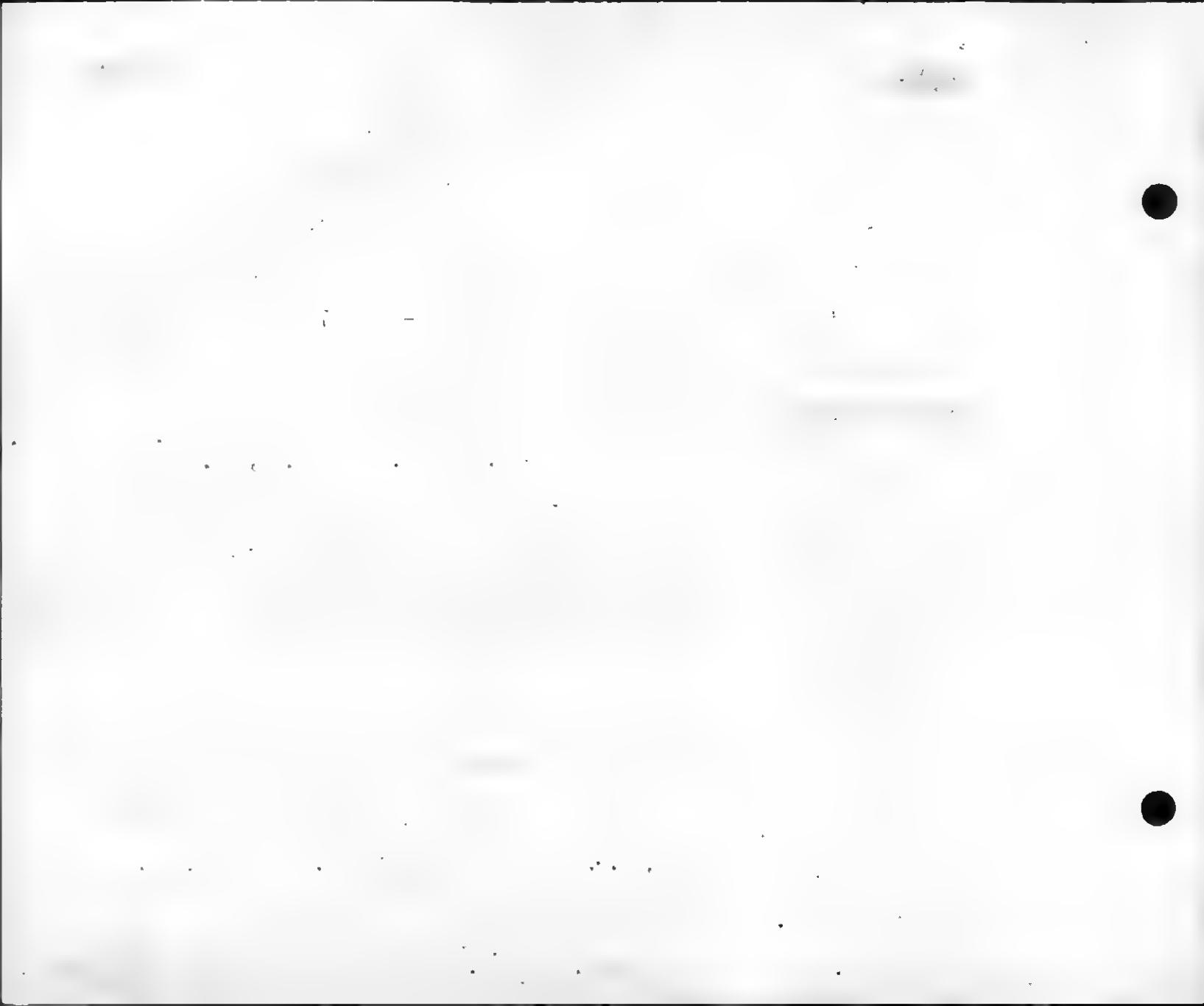
CERTIFICATE OF DEATH

14588

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<p>1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND</p> <p>b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly</p> <p>c. LENGTH OF STAY IN 1b 3 days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital</p>		<p>2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland</p> <p>b. COUNTY</p> <p>c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro</p> <p>d. STREET ADDRESS 14042 Willowby Drive</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3 NAME OF DECEASED (Type or print) Annie XXXXXX A</p> <p>4 DATE OF DEATH October 11 1966</p>		<p>5 SEX Female 6 COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. AGE (In years last birthday) 79 XX yrs</p>	
<p>10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>		<p>10b KIND OF BUSINESS OR INDUSTRY Seamstress</p> <p>11. BIRTHPLACE (County & State, or foreign country) Maryland</p>	
<p>13. FATHER'S NAME XXXXXX Silas Talbert</p>		<p>14. MOTHER'S MAIDEN NAME Jessie Talbert</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 17 INFORMANT Mrs. Edna L. King Rt. #1, Box. 353 -Tippett</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPRESSION DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO stating the underlying cause (c) Pleural Effusion - unknown etiology last Unknown</p>		<p>19. INTERVAL BETWEEN ONSET AND DEATH Years</p>	
<p>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1) Arteriosclerosis 2) Diabetes Mellitus</p>		<p>21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</p>	
<p>20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.</p>		<p>20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f (City or town) Carrollton (County) Md. (State)</p>	
<p>21. I certify that (this hospital) attended the deceased from October 8, 1966, to October 11, 1966, that (we) lost the deceased alive on October 11, 1966, and that death occurred at 4:10 P.M. from causes and on the date stated above.</p>			
<p>22a. SIGNATURE Roger B. Ingham, M.D.</p>		<p>22b. DATE SIGNED 10-12-66</p>	
<p>22c. PHYSICIAN'S NAME (Type) Roger B. Ingham, M.D.</p>		<p>22d. ADDRESS 5701 85th Ave. Carrollton, Md.</p>	
<p>23a BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF Oct. 14-66 23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery</p>	
<p>24 FUNERAL DIRECTOR Simmons Bros.</p>		<p>ADDRESS Wash. DC. 25a REC'D BY REGISTRAR Simmons Bros. Funeral Home 1661-Gd. Hope Rd. SE DATE OCT 14 1966 25b REGISTRAR'S SIGNATURE Charles Judge</p>	



1 (M)
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14589

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Prince George General Hospital		d. STREET ADDRESS Box 13, Glen Dale Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Armstead	Last Huston
4. DATE OF DEATH	Month 10	Day 10	Year 1966
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov. 1914
9. AGE (in years last birthday) 51 yrs.	10. FUNDER 1 YEAR Months Days	11. FUNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Huston		14. MOTHER'S MAIDEN NAME Maggie Frey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-12-0079	
17. INFORMANT Mr. William Huston		Address Box 917	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis, left temporal lobe 332A DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH, Md.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10-11-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIALY Harmony Memorial Park
24. FUNERAL DIRECTOR		ADORESS	23d. LOCATION (City, town or county) (State) Sheriff Rd. Landover, Md.
W. W. CHAMBERS CO., Riverdale, Maryland		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE OCT 17 1966 Charles Judge

1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

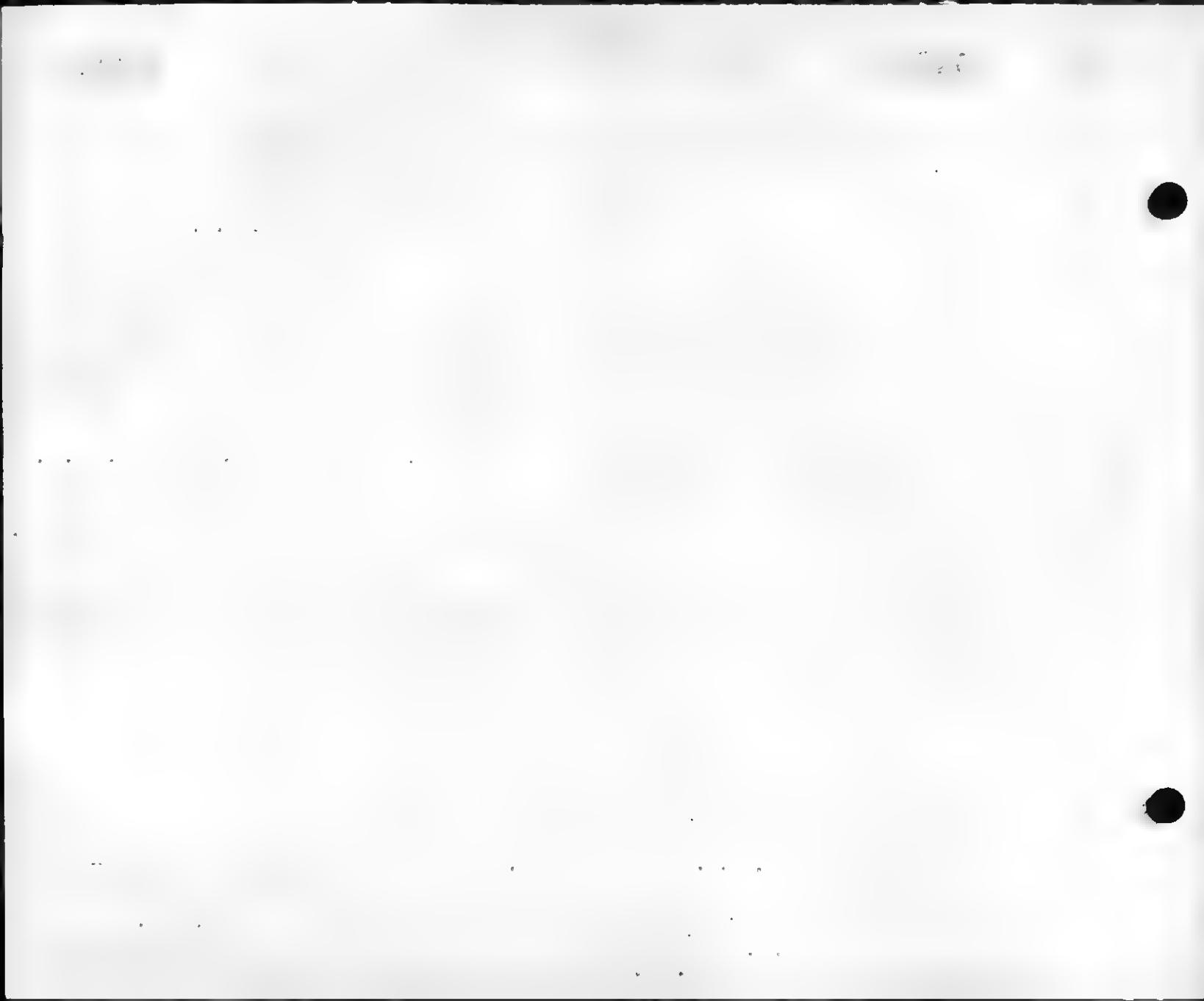
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14589 14590

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		e. STREET ADDRESS Washington 5521 Colorado Avenue, N.W.	
3. NAME OF DECEASED (Type or print) Silas		First H Middle Last	4. DATE OF DEATH Month Day Year 10 18 19 66
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher-Railroad		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT		2. Address Lucile J. Jacobs Mt. Vernon, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED John Kehoe, M.D. Riverdale, Md. 10-19-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/21/66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington		23d. LOCATION (City, town or county) Suitland, Md.	25a. REC'D BY REGISTRAR DATE OCT 24 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

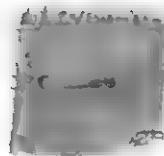
CERTIFICATE OF DEATH

14591

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and event, within 72 hours after death.

14590

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial		d. STREET ADDRESS 2904 Jamestown Road	
3. NAME OF DECEASED (Type or print) Helen		First James	Middle Month October Day 12 Year 1966
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 10-22-75		9. AGE (In years last birthday) 90 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Fisher		14. MOTHER'S MAIDEN NAME Helen Elizabeth Hines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-56-0549	
17. INFORMANT Margaret Rollman		Address 7 Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure 2 yrs.</u> DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen. arteriosclerosis (duration unknown)</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cystic fibrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-22-10-14, 1966</u> , to <u>10-12, 1966</u> , that (I) (we) last saw the deceased alive on <u>10-12, 1966</u> , and that death occurred at 7:20AM, from causes and on the date stated above.			
22a. SIGNATURE <u>C. J. Houmann</u>		22b. DATE SIGNED 10-12-66	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF Oct 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mountain View Cemetery
23d. LOCATION (City or Town) Sharpsburg		(County) (State) Md.	
24. FUNERAL DIRECTOR F Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE OCT 17 1966
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film 633 11/25/66 mh

CERTIFICATE OF DEATH

14592

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and again, within 72 hours after death.

14591

1 PLACE OF DEATH a. COUNTY Prince Georges		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 904 64th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First: Mary Middle: E Last: Jefferson		4. DATE OF DEATH October 3 1966	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 23, 1890		10. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) Blackstone Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Miffie Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. J.W. Brown 5-403 Addison St. Fend	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Dr. Diabetes Acidosis Diabetes Mellitus	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cerebrovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from Sept. 18, 1966, to October 3, 1966, that (B) (we) last saw the deceased alive on October 3, 1966, and that death occurred at 6:30 AM, from causes and on the date stated above.		22a. SIGNATURE A. Clark Holmes, M.D.	
22b. DATE SIGNED 10/3/66		22d. ADDRESS 4108 Pratt St. Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial		23d. LOCATION (City or Town) (County) (State) Suitland Rd., Suitland, Md.	
24. FUNERAL DIRECTOR J. S. Washington Sons 4925 Prince Avenue		25a. REC'D BY REGISTRAR OCT 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14582

14593

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. That page 2 remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Geo		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md b. COUNTY P-G				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.G. GEN Hospital		d. STREET ADDRESS Marlow Heights				
3. NAME OF DECEASED (Type or print) Robert L. Jenkins		First R	Middle L			
Last Jenkins		Last J	4. DATE OF DEATH Oct 12 1966			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1898			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Police		10b. KIND OF BUSINESS OR INDUSTRY D.C. Police Dept.	9. AGE (In years last birthday) 68 yrs.			
11. BIRTHPLACE (County & State, or foreign country) CHAS Co Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James Jenkins		14. MOTHER'S MAIDEN NAME MARY E SWANN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) yes		16. SOCIAL SECURITY NO. 577-46-0605	17. INFORMANT Joseph Jenkins			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary artery disease (c)		Address Hughesville 77d				
INTERVAL BETWEEN ONSET AND DEATH immediate		2 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While	20f. (City or town) None	(County) None	(State) None
21. I certify that (I) (his hospital) attended the deceased from July 1966 to October 1966 , that (I) (he) last saw the deceased alive on Oct 12 1966 , and that death occurred at M , from the causes and on the date stated above.						
22a. SIGNATURE J. Sanford Young		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/13/66
22c. PHYSICIAN'S NAME (Type) J. Sanford Young		22d. ADDRESS 4400 Stamp Rd., Temple Hills, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 17, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ARLINGTON NAT. CEMETERY	23d. LOCATION (City, town, or county) ARLINGTON VA.		(State) VA.
24. FUNERAL DIRECTOR Hunt Funeral Home Waldorf MD		ADDRESS Waldorf MD	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14594

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and only event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
a. COUNTY Prince George's MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Oak Crest	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William H. Jenkins		4. DATE OF DEATH 10 21 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 29 May 1907		10. AGE (In years last birthday) 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Tilden Jenkins (deceased)		14. MOTHER'S MAIDEN NAME Laura Jane Frye (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOC. SEC. NO.	
17. INFORMANT Mrs. Harriet Spike, Laurel, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive interventricular hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Cerebral Hemorrhage, Right internal capsule		2 hrs.	
(b) Hypertensive vascular disease		unknown	
DUE TO Fatty nutritional cirrhosis (c)		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED 10-21-66	
23a. BURIAL, CREMATION, REMOVAL (If any) BURIAL		23b. DATE THEREOF Oct. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery, Laurel, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR DATE OCT 26 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)								
a. COUNTY <i>Prince George</i>			a. STATE <i>MARYLAND</i>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Suitland</i>			c. LENGTH OF STAY IN 1B <i>Suitland</i>								
c. LENGTH OF STAY IN 1B			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glass Manor</i>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suitland Nursing Home</i>			d. STREET ADDRESS <i>407- Garden St</i>								
3. NAME OF DECEASED (Type or print)			First <i>Gertrude</i>	Middle <i>A.</i>	Last <i>Jochum</i>	4. DATE OF DEATH <i>10-15 196</i>	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>			6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/18/1892</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Wheeling, West Va.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Fred Peters</i>			14. MOTHER'S MAIDEN NAME <i>MARY Boss</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>			16. SOCIAL SECURITY NO.			17. INFORMANT <i>Bernice Mallon</i>			Address <i>407 Garden St MD 20201</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Congestive Heart Failure								
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			Arteriosclerotic Heart Disease								
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>9/25, 196</i> to <i>10/16, 196</i> , that (I) (we) last saw the deceased alive on <i>10/16, 196</i> , and that death occurred at <i>11:15 PM</i> , from the causes and on the date stated above.			22b. DATE SIGNED <i>10/17/66</i>								
22a. SIGNATURE <i>Max E Feldman</i>			22b. DATE SIGNED <i>10/17/66</i>								
22c. PHYSICIAN'S NAME (Type) <i>DR. MAX Feldman</i>			22d. ADDRESS <i>3800 South Capitol St.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>Oct. 19-1966</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington Nat'l Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>		
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>			ADDRESS <i>Simmons Bros. 1661-Good Hope Rd. SE Wash DC</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE		
25c. DATE <i>OCT 19 1956</i>											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14595

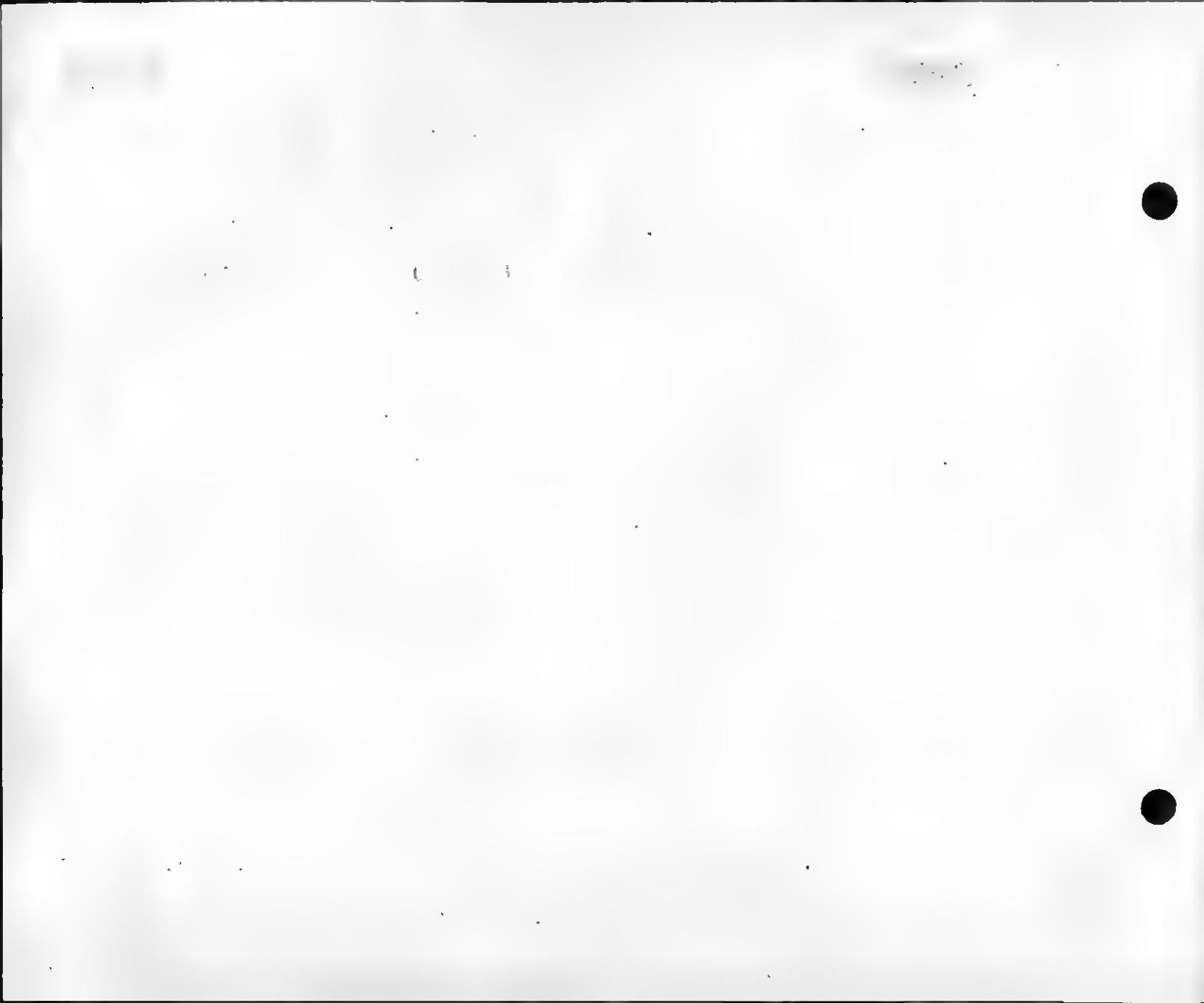
CERTIFICATE OF DEATH

14596

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's						
c. LENGTH OF STAY IN b. 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 8416 George Palmer Highway						
3 NAME OF DECEASED (Type or print) Delores Morina (Johnson)		4 DATE OF DEATH October 20 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH JAN 28, 1931					
9 AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS					
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None						
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Beetie Tolliver						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None						
17. INFORMANT Vera Matthews 6305 Southern Ave		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19. INTERVAL BETWEEN ONSET AND DEATH Hepatic failure Cerebrovascular disease						
DUE TO (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Emphysema, Auto								
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (1) (this hospital) attended the deceased from October 11 1966 to October 20 1966 that (1) (we) last saw the deceased alive on October 20 1966, and that death occurred at 6:30 P.M. from causes and on the date stated above.								
22a. SIGNATURE Lee Lacer		22b. DATE SIGNED 10-21-66						
22c. PHYSICIAN'S NAME (Type) Dr. Lee Lacer,		22d. ADDRESS Prince George's Genl. Hosp., Cheverly Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-25-66		23b. DATE THEREOF 10-25-66		23c. NAME OF CEMETERY OR CREMATORIAL Queens Chapel		23d. LOCATION (City or Town) Morgantown Md	(County)	(State)
24. FUNERAL DIRECTOR Washington ADDRESS 14925 1st Ave. N.E.				25a. RECD BY REGISTRAR DATE OCT 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14596

CERTIFICATE OF DEATH

14597

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hyattsville Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>	
3. NAME OF DECEASED (Type or print) <i>Sadie</i>		First <i>Sadie</i>	Middle <i>May</i>
4. DATE OF DEATH <i>September 4 1966</i>		Last <i>Johnson</i>	5. SEX <i>FEMALE</i>
6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1883</i> <i>8-13-87</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE (In years last birthday) <i>83 82 yrs.</i>
13. FATHER'S NAME <i>Edgar Miller</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Chicago, Illinois</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>578-01-3265-D</i>	17. INFORMANT <i>Mr. Albert L. Johnson</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>		Address <i>5406- 14th Ave., Hy., MA</i>	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>recent years</i>	
DUE TO <i>Severe generalized arteriosclerosis</i>		DUE TO <i>Cerebral vascular insufficiency</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Myelosclerosis Disease ② Osteomyelitis - stormy precipitate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>911 Silver Spring Ave</i>
20f. (City or town) <i>Colmar Manor, Md.</i>		(County) <i>Montgomery</i>	
(State) <i>Maryland</i>			
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>10/1/66</i> , 19 <i>66</i> , to <i>10/14</i> , 19 <i>66</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>10/14</i> , 19 <i>66</i> , and that death occurred at <i>5:30</i> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Harold W. Draper</i>		22b. DATE SIGNED <i>10/14/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Harold W. Draper M.D.</i>		ATTENDING M.D. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS <i>911 Silver Spring Ave</i>		22e. ADDRESS <i>Colmar Manor, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Socty) <i>Cremation</i>		23b. DATE THEREOF <i>10/7/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cem.</i>
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. ADDRESS <i>Mt. Rainier, Maryland</i>	25b. REC'D BY REGISTRAR <i>Colmar Manor, Md.</i>
		DATE <i>OCT 10 1966</i>	REGISTRAR'S SIGNATURE <i>Charles Judge</i>

11 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

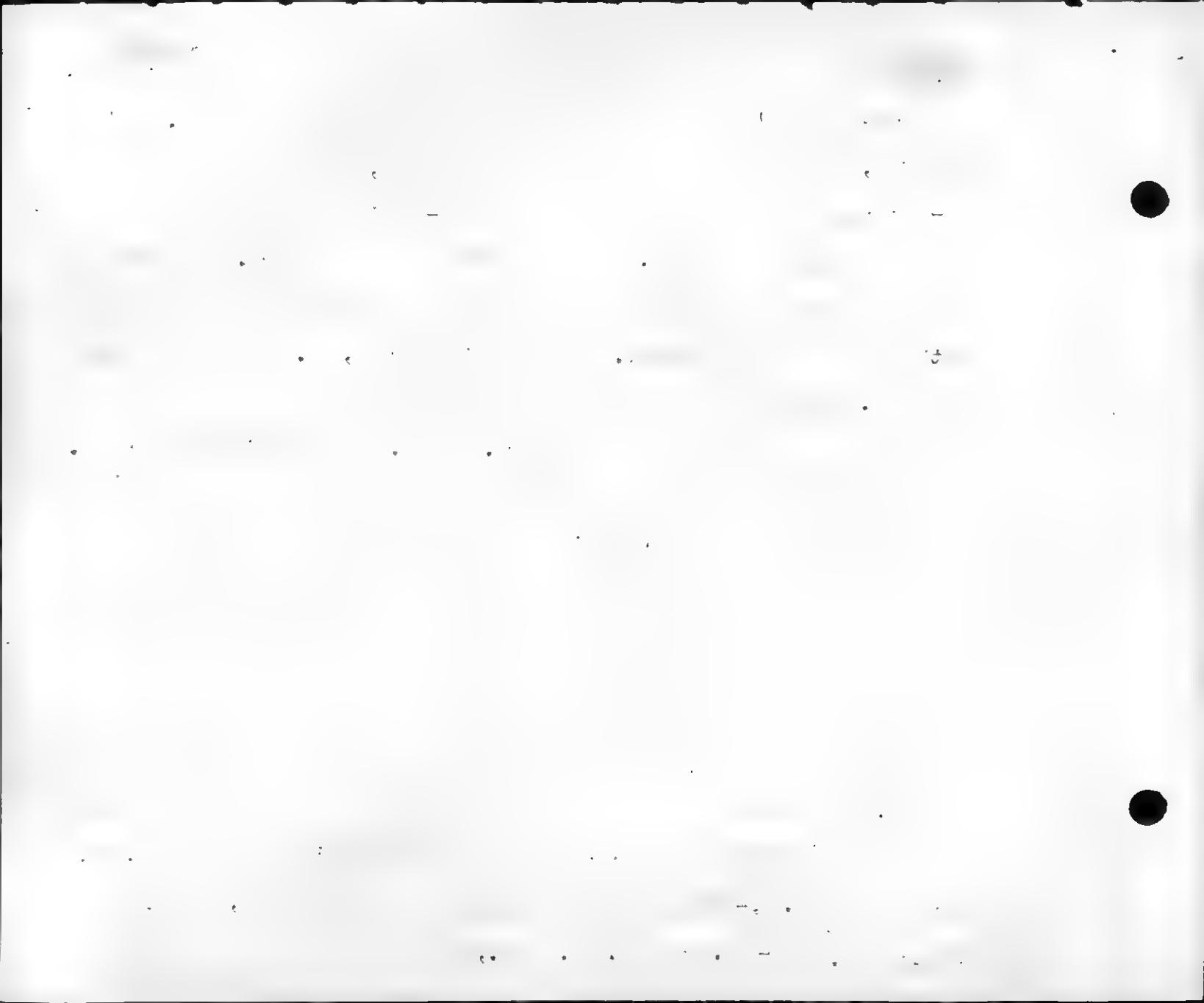
14597

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14598
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6223 Livingston Road SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle I.	Last KEANE
4. DATE OF DEATH Oct. 15th 1966	Month Year Day 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 17th 1905
9. AGE (in years last birthday) 61 yrs.	10. FUNDER 1 YEAR Months Days	11. FUNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY US/ Gov.	11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pa.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas A. Keane	14. MOTHER'S MAIDEN NAME Ella Gray	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Ruth A. Keane (Wife) Same as # 2.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.	DUE TO (b) Empty Sema	INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1966</u> to <u>10-15 1966</u> , that (I) (we) last saw the deceased alive on <u>10-13 1966</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE Etienne Szollosi	22b. DATE SIGNED 10-15/66		
22c. PHYSICIAN'S NAME (Type) Etienne Szollosi, M.D.	22d. ADDRESS 2 Parkway Drive, Forest Hgts. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 18-1966	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros.	ADDRESS 1661- Gd. Hope Rd. SE. Wash., DC	25a. REC'D BY REGISTRAR DATE OCT 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

BP



1
FOR STATE
HEALTH DEPT.

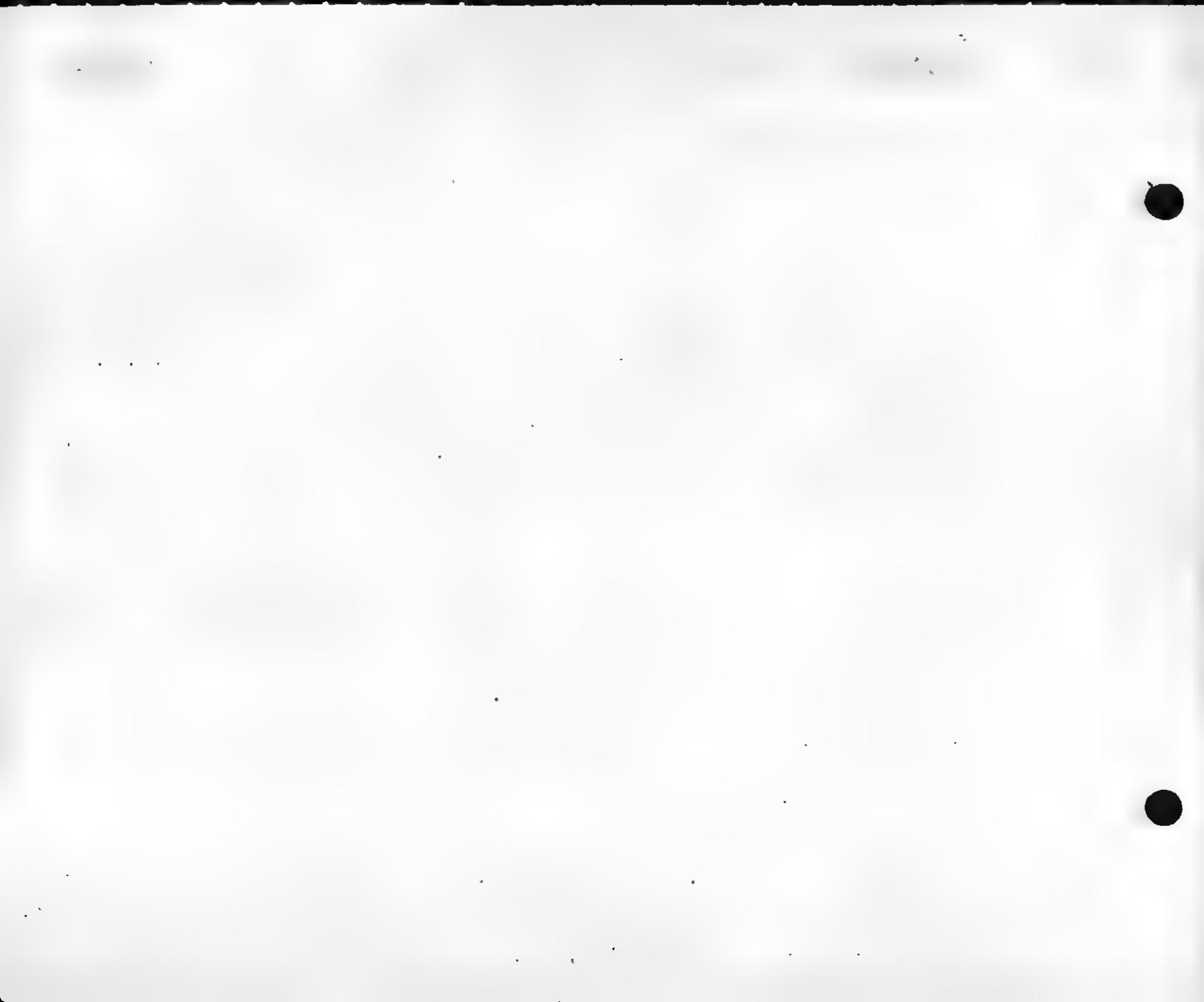
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14598 **14598**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Prince George's b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. LENGTH OF STAY IN 1b Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3501 Shepard Street	
3. NAME OF DECEASED (Type or print)	First Roberta	Middle Kelly	Last Knight
4. DATE OF DEATH	Month 10	Day 15	Year 1966
5. SEX	6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 18 April 1942
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 24 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Myrtle Kilby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
		17. INFORMANT Louis R. Knight Same as #2 (husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest		Address INTERVAL BETWEEN ONSET AND DEATH minutes	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self in chest.	
20c. TIME OF INJURY Month, Day, Year about 6:00pm p.m. 10-15-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bedroom of home
		20f. (City or town) same as #2	(County) same as #2 (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 10-17-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/66	
		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
		25a. REC'D BY REGISTRAR DATE OCT 24 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
3500 4-64

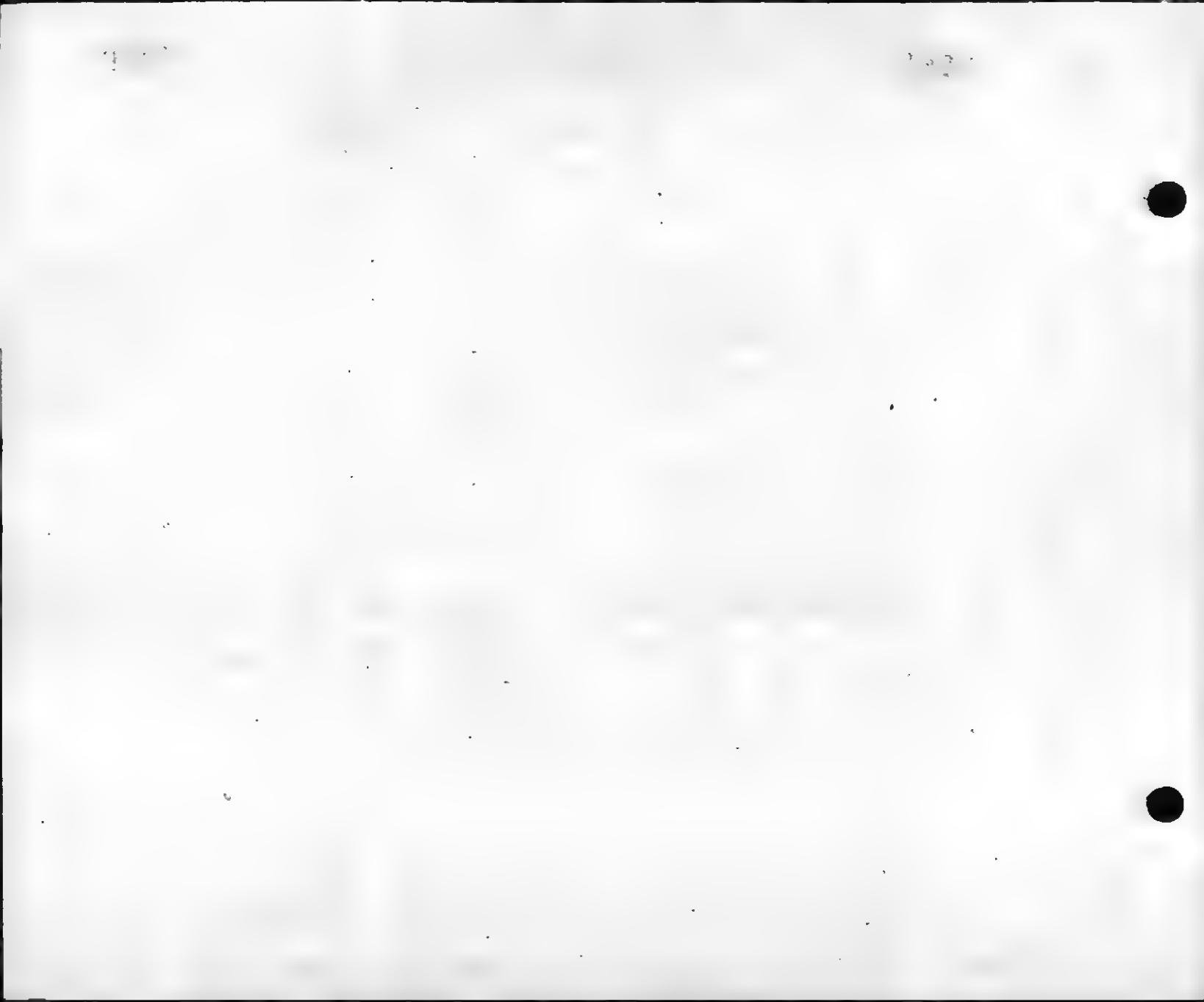
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14600

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 16		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH 1920 Oct 5 1966	Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17 1932		9. AGE (in years last birthday) 14 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Joseph Kulac, Jr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 70-ounce bottle of beer + DUE TO (b) Suicide - Suicidal intent, fell into underlying cause last. DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Chew of all meat, all day, all night		20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 p.m. 1966 p.m. 12-3 1966		20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-5-64					
ACTUAL SIGNATURE Charles J. Charles		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) J. Charles Charles		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 8, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION (City, town or county) Colmar Manor, Md (State)	
24. FUNERAL DIRECTOR M. J. Charles Charles		ADDRESS 254 Carroll St, 26 W, Washington, D.C. 20012		25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

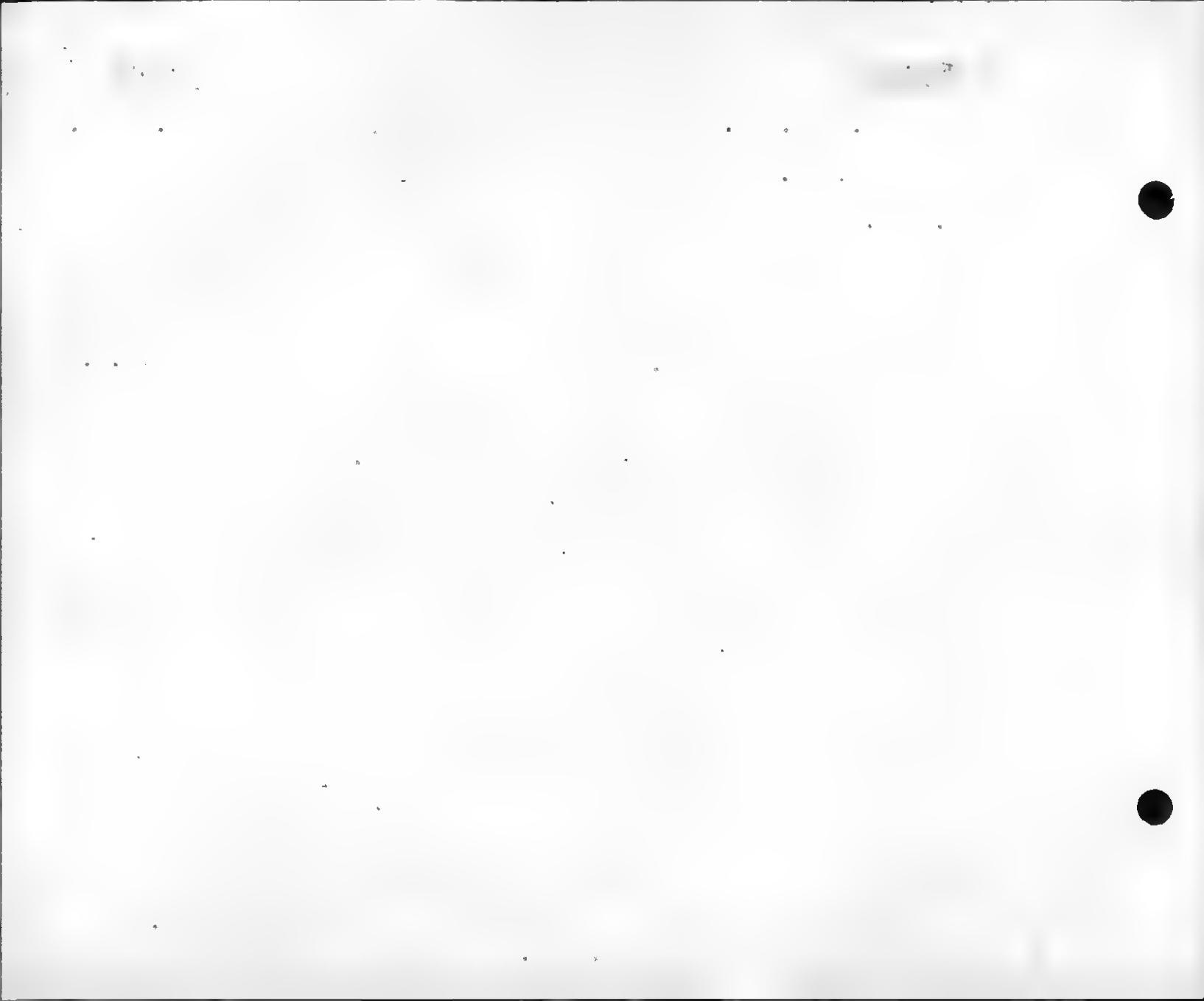
14601

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Pr. Geo. Co.		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write R-RAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.			
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 5076 Silver Hill Ct.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) John		First Lacy	Middle Mae		
4 DATE OF DEATH October 10, 1966	Month October	Day 10	Year 1966		
5 SEX Male	6. COLOR OR RACE white	7 MARRIED WIDOWED	NEVER MARRIED DIVORCED		
8 DATE OF BIRTH 8/31/1898	9. AGE (in years 68 at first birthday) yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Met. Club			
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Lacy		14. MOTHER'S MAIDEN NAME Jennie Maguire			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-01 3833 Mrs Mae P. Lacy wife Same #2d			
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Pulmonary embolus</u> DUE TO DUE TO DUE TO C. <u>Arterio-occlusive heart disease</u>		19. INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 23, 1966</u> , to <u>10/11, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/11, 1966</u> , and that death occurred at <u>2:40 P.M.</u> , from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE <u>Henry J. Palacios</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 10/13/1966	
22c. PHYSICIAN'S NAME (Type) Henry J. Palacios		22d. ADDRESS 6800 Indian Head Hwy, Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.	23d. LOCATION (City or Town) Washington, D.C. (County) (State)	
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E.		25a. ADDRESS Lee Funeral Home 300-4th St. N.E.		25b. REC'D BY REGISTRAR Charles J. Judge	25c. REGISTRAR'S SIGNATURE
				DATE OCT 13 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14601

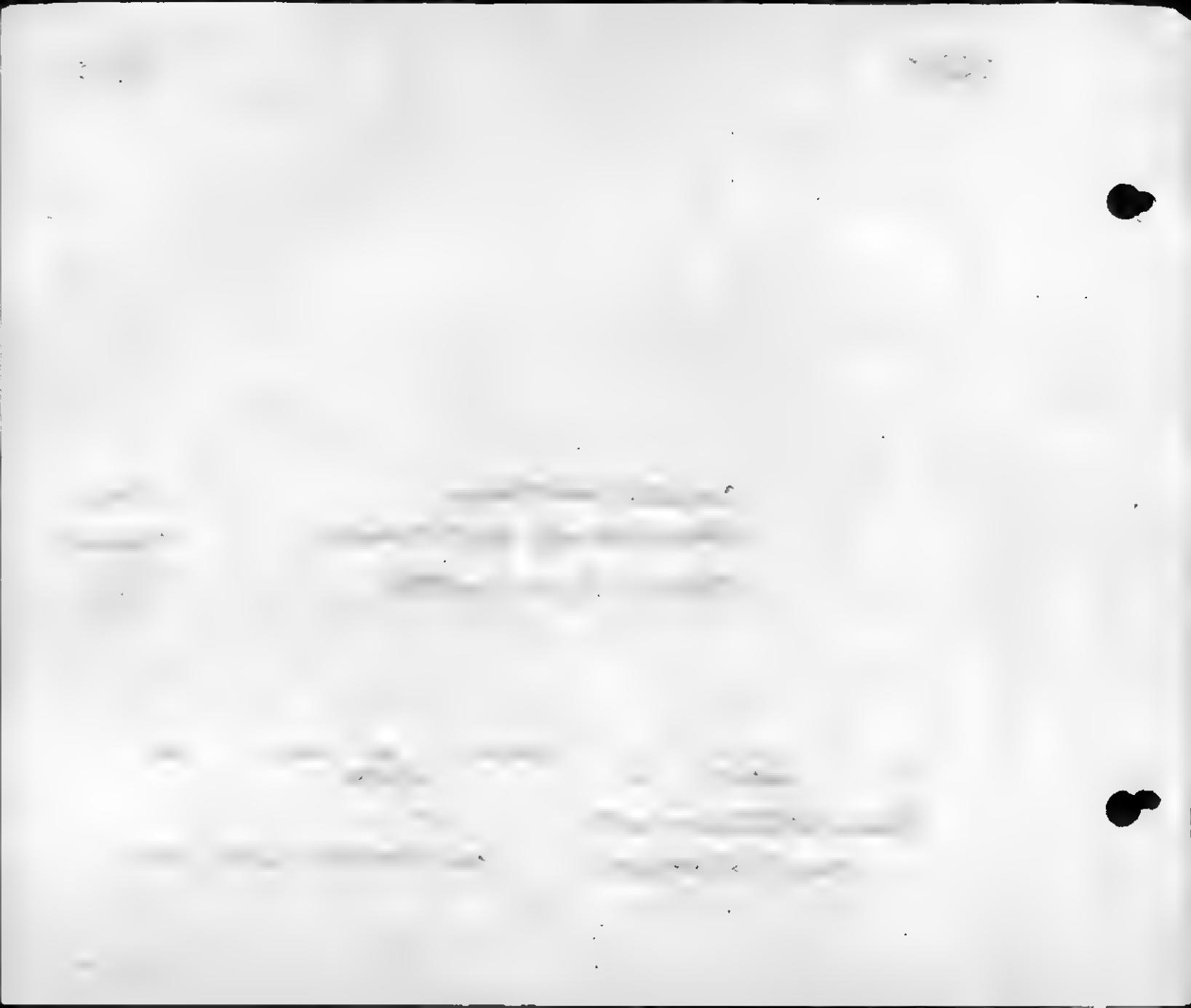
14602

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY PRINCE GEORGE		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Doc Prince George Hospital		d. STREET ADDRESS 2902 64th Ave.	
e. FATHER'S NAME FRANCES C. LEAKE		e. DATE OF DEATH Oct. 4 1966	
f. SEX Female		f. DATE OF BIRTH Mar. 29, 1895	
g. COLOR OR RACE White		g. AGE (In years last birthday) 71 yrs.	
h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		h. IF UNDER 1 YEAR Months Days	
i. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		i. IF UNDER 24 HRS. Hours Min.	
j. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F.W.		j. 10b. KIND OF BUSINESS OR INDUSTRY	
k. 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md		k. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
l. 13. FATHER'S NAME Joseph Funk		l. 14. MOTHER'S MAIDEN NAME Mary Logovitz	
m. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		n. 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Catherine Windsor Address 6708 Stanton Rd Md	
o. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		p. 19. INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		q. PROGRESSIVE 8 yrs.	
DUE TO (c)		r. 20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
s. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		s. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
t. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		u. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
v. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		w. 20f. (City or town) (County) (State)	
x. 21. I certify that (I) (this hospital) attended the deceased from Mar. 26, 1947, to Oct. 4, 1966, that (I) (we) last saw the deceased alive on Sept. 27, 1966, and that death occurred at 11:30 PM the causes and on the date stated above.		y. 22b. DATE SIGNED	
z. 22a. SIGNATURE Leland E. Stevenson M.D.		z. 22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
aa. 22c. PHYSICIAN'S NAME (Type) Leland E. Stevenson		bb. 22d. ADDRESS 2101 R-ST. N.W. - DC. 20008	
cc. 23a. BURIAL/CREMATION, REMOVE (Specify) BURIAL		cc. 23b. DATE THEREOF Oct. 8, 1966	
cc. 23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S		cc. 23d. LOCATION (City, town or county) Wash. D.C. (State)	
dd. 24. FUNERAL DIRECTOR'S SIGNATURE FRANK GEIER'S SONS CO.		ee. 25a. REC'D BY REGISTRAR OCT 7 1966	
ee. 25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14603

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		b. COUNTY Prince George's	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7243 Hilton Street	
3. NAME OF DECEASED (Type or print) Alfonzo Linwood Leath		4 DATE OF DEATH 10 23 19 66	Month Day Year
S. SEX Male	6 COLOR OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH 26 Feb. 1935
9 AGE (In years last birthday) 31 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Charlie Leath	
14. MOTHER'S MAIDEN NAME Ardelia Neal		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Clara Satterfield-912 Shepherd N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left hemothorax, 1000cc.</u>		INTERVAL BETWEEN ONSET AND DEATH	
X164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>from multiple rib fractures</u> (c) <u>From trauma- auto accident</u>		DUE TO Multiple puncture wounds of left lung	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision.	
20c. TIME OF INJURY Month, Day, Year Hour am 4:10am 10-23- 966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) Prince George Co., Md. (State) Baltimore Washington Parkway near Rt. 50.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
22. DATE SIGNED 10-24-66		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE THEREOF 10-24-66		23c. NAME OF CEMETERY OR CREMATORIUM	
23d. LOCATION (City or Town) BURLINGTON, N.C. (County) (State)		25a. REC'D BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR FRAZIER'S FUNERAL HOME- WASH, D.C.		25b. REGISTRAR'S SIGNATURE DATE OCT 26 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14603

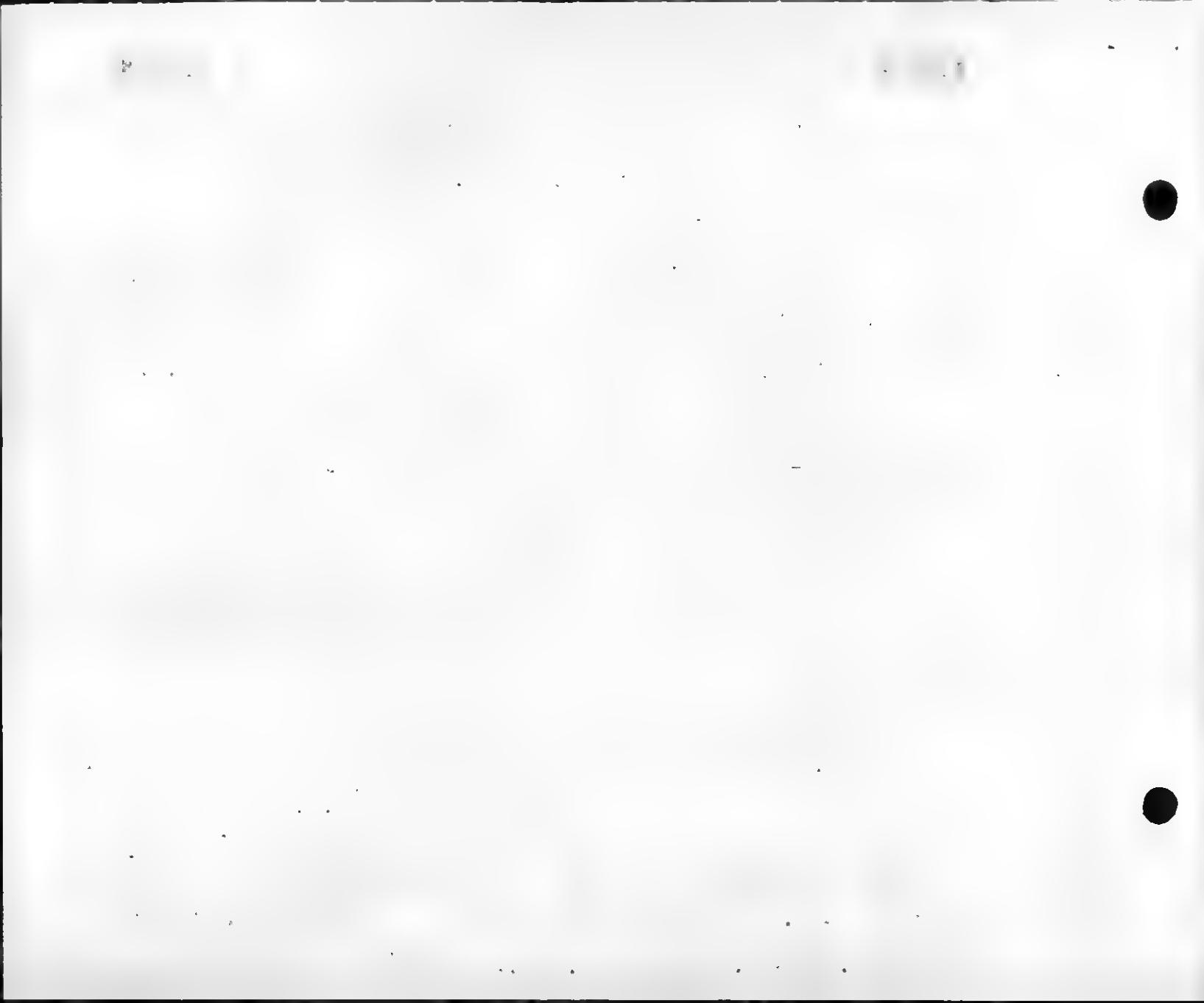
CERTIFICATE OF DEATH

14604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN b 205 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle EVERETT	Last LE SUEUR
4. DATE OF DEATH OCTOBER 29 1966	Month Year	Month Year	Day Year
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED X NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 OCT 1931
9. AGE (In years lost birthday) 35 yrs	10. IF UNDER 1 YEAR Months 35	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) COUNTER PARTS MAN		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE	
11. BIRTHPLACE (County & State, or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EVERETT LE SUEUR		14. MOTHER'S MAIDEN NAME EFFIE CLOUTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) YES 1951-1955		16. SOCIAL SECURITY NO. 015-24-5494	
17. INFORMANT HARRIETTE LE SUEUR-WIFE-SAME AS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY FAILURE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
DUE TO 201X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost.		DUE TO (b) HODGKINS DISEASE.	
DUE TO		DUE TO (c)	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) ANDREWS		(County) PRINCE GEORGE'S	
(State) MD			
21. I certify that X (this hospital) attended the deceased from 7 APR 1966 to 29 OCT 1966 , that X (we) last saw the deceased alive on 29 OCT 1966 , and that death occurred at 1:15M , from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Hallowell GetUSAFAFB</i>		ATTENDING PHYS. <input type="checkbox"/>	MED. A.M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22b. ADDRESS USAF HOSPITAL ANDREWS		22c. DATE SIGNED 29 OCT 66	
22d. ADDRESS ANDREWS AFB, WASHINGTON DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1st 1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
23d. LOCATION (City or Town) Arlington		(County) Virginia	
(State) MD			
24. FUNERAL DIRECTOR <i>Simmons Bros.</i> Simmons Bros. 1661-Gd. Hope Road SE, Wash., DC		25a. ADDRESS 1661-Gd. Hope Road SE, Wash., DC	25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>
25c. DATE NOV 1 1966		25d. REC'D BY REGISTRAR NOV 1 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14604

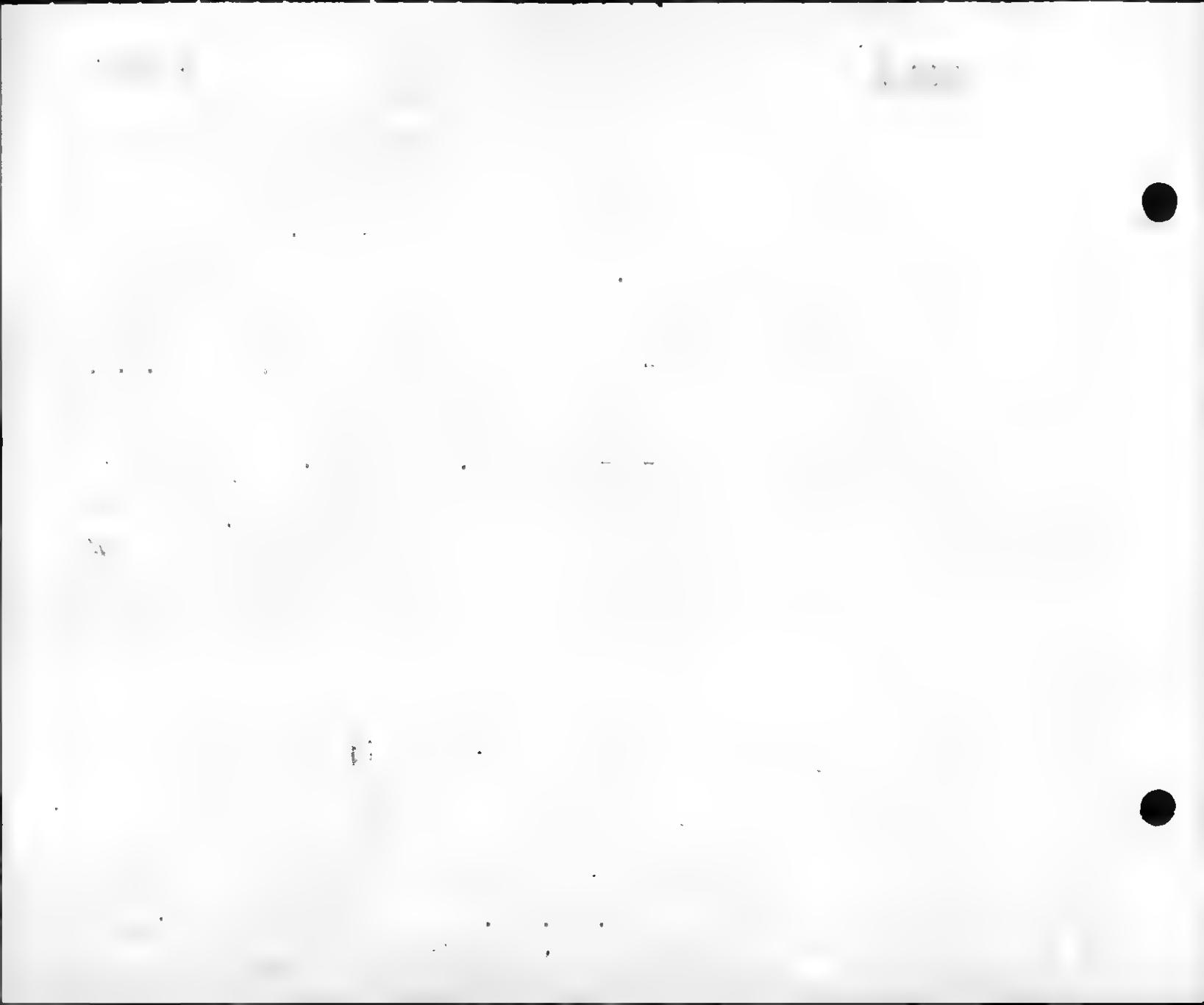
CERTIFICATE OF DEATH

14605

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 1 hr. 15 min			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5810 84th Ave.		
3. NAME OF DECEASED (Type or print) Paul E. Luttner			4. DATE OF DEATH Oct. 30 1966	Month	Day
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED X NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH 12-7-23	9. AGE (In years last birthday) 42 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			11. BIRTHPLACE (County & State, or foreign country) Latrobe, Penna.		
13. FATHER'S NAME Joseph Luttner			14. MOTHER'S MAIDEN NAME Mary Stiener		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WWII			16. SOCIAL SECURITY NO. 191-12-8679 17. INFORMANT Mrs. Margaret H. Luttner (above Address (Wife) address)		
18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) JUNE 1961 (County) 10-30, 1966 (State) Hyattsville MD
21. I certify that (I) (this hospital) attended the deceased from JUNE 1961 to 10-30, 1966 that (I) (we) last saw the deceased alive on 10-30, 1966 and that death occurred at 10-30, 1966 M. from causes and on the date stated above.			22b. DATE SIGNED 10/30/66		
22a. SIGNATURE William D. Rosson MD			ATTENDING PHYS. MD	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) William D. Rosson			22d. ADDRESS 5701 85th Ave Hyattsville MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/66	23c. NAME OF CEMETERY OR CREMATORIAL Arl. Nat. Cem.	23d. LOCATION (City or Town) Arlington, Va. (County) VA (State)	
24. FUNERAL DIRECTOR Home Inc.			Nalley's Funeral ADDRESS Mt. Rainier, Maryland	25a. REC'D BY REGISTRAR DATE NOV 4 1986	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 27 10/20/66 mh

CERTIFICATE OF DEATH

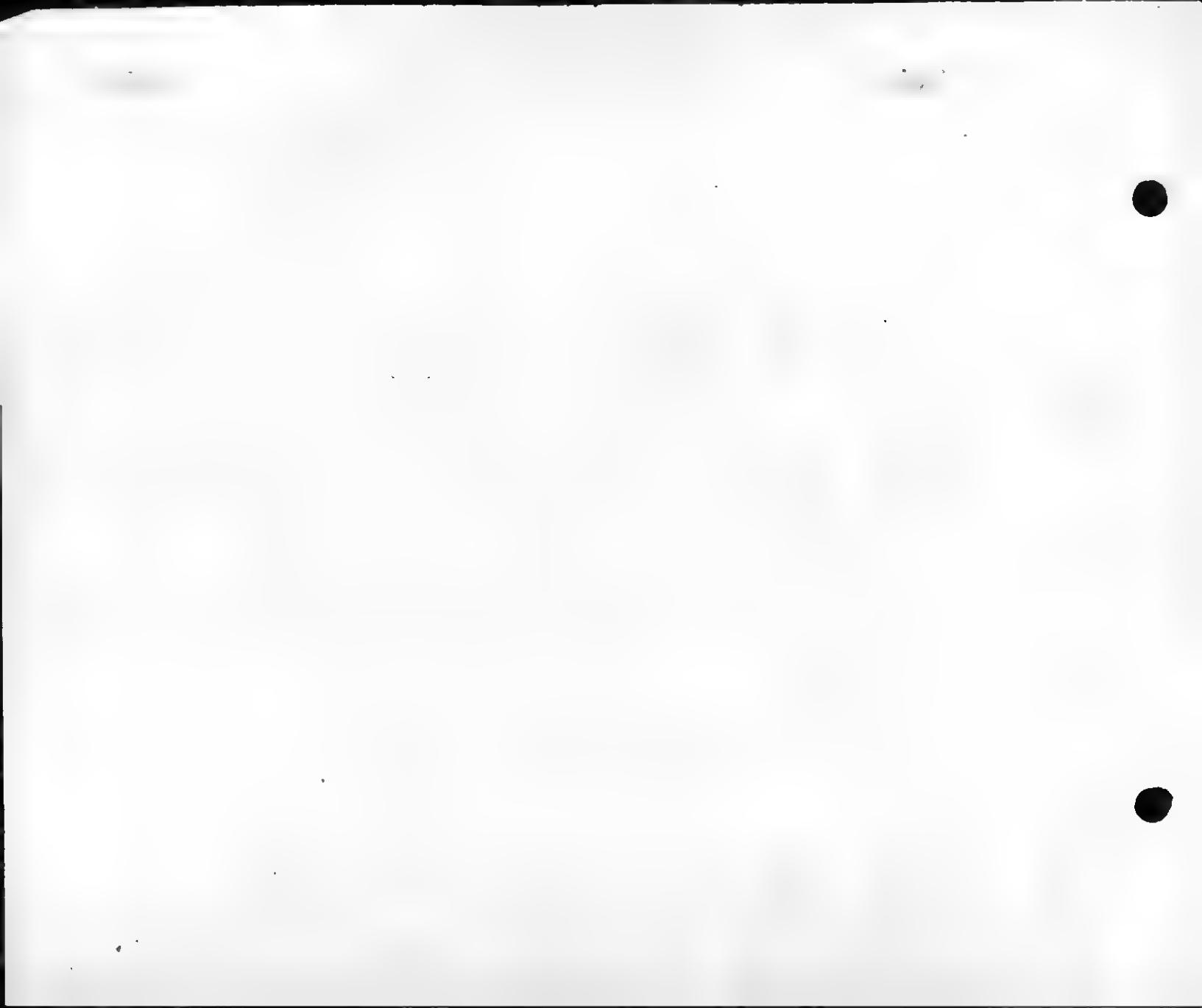
14806

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the certificate should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (Outs de corporate limits, write RURAL and give nearest town) <i>4007-6 Hyattsville, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Magnolia Gardens Nursing Home 4007 Warner Ave</i>		d. STREET ADDRESS <i>Tafton</i>	
3. NAME OF DECEASED (Type or print) <i>James</i>		First <i>James</i>	Middle <i>Oscar</i>
3. SEX <i>Male</i>		COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED
10a. USIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret BUTCHER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat Packing Co.</i>	
13. FATHER'S NAME <i>Michael J. Lynn</i>		14. MOTHER'S MAIDEN NAME <i>Margaret HELEY</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>4539 Kirby Parkway</i>	
17. INFORMANT <i>Joseph Lynn</i>		18. DATE OF BIRTH <i>July 9, 1880</i>	
19. BIRTHPLACE (County & State, or foreign country) <i>Pennsylvania</i>		20. AGE (In years lost birthday) <i>86 yrs</i>	
21. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		22. IF UNDER 1 YEAR Months Days Hours Min	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>334X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		24. DATE OF DEATH <i>General anemias</i> <i>Cerebral arteriosclerosis</i> <i>Generalized arteriosclerosis</i>	
25. INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>		26. DUE TO <i>3 years.</i>	
27. DUE TO <i>5 years</i>		28. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. MEDICAL CERTIFICATION		30. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
31a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
32a. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		32b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	32c. (City or town) (County) (State) <i>11 Oct 1966</i>
33. I certify that (I) (this hospital) attended the deceased from <i>July 1964</i> to <i>11 Oct 1966</i> that (I) (we) last saw the deceased alive on <i>11 Oct 1966</i> , and that death occurred at <i>4 A.M.</i> from causes and on the date stated above.		34. ATTENDING MED. PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <i>Thomas G. Maloney M.D.</i> <i>11 Oct 66</i>	
35. PHYSICIAN'S NAME (Type) <i>THOMAS G. MALONEY</i>		36. ADDRESS <i>4814 71st Ave. Woodlawn</i>	
37. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		38. DATE THEREOF <i>10/14/66</i>	39. NAME OF CEMETERY OR CREMATORIAL <i>Queen of Peace</i>
40. FUNERAL DIRECTOR <i>Francis Graschi's Son's</i>		41. ADDRESS <i>Hyattsville, Md.</i>	
42. REC'D BY REGISTRAR <i>Charles Judge</i>		43. DATE <i>OCT 13 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14606

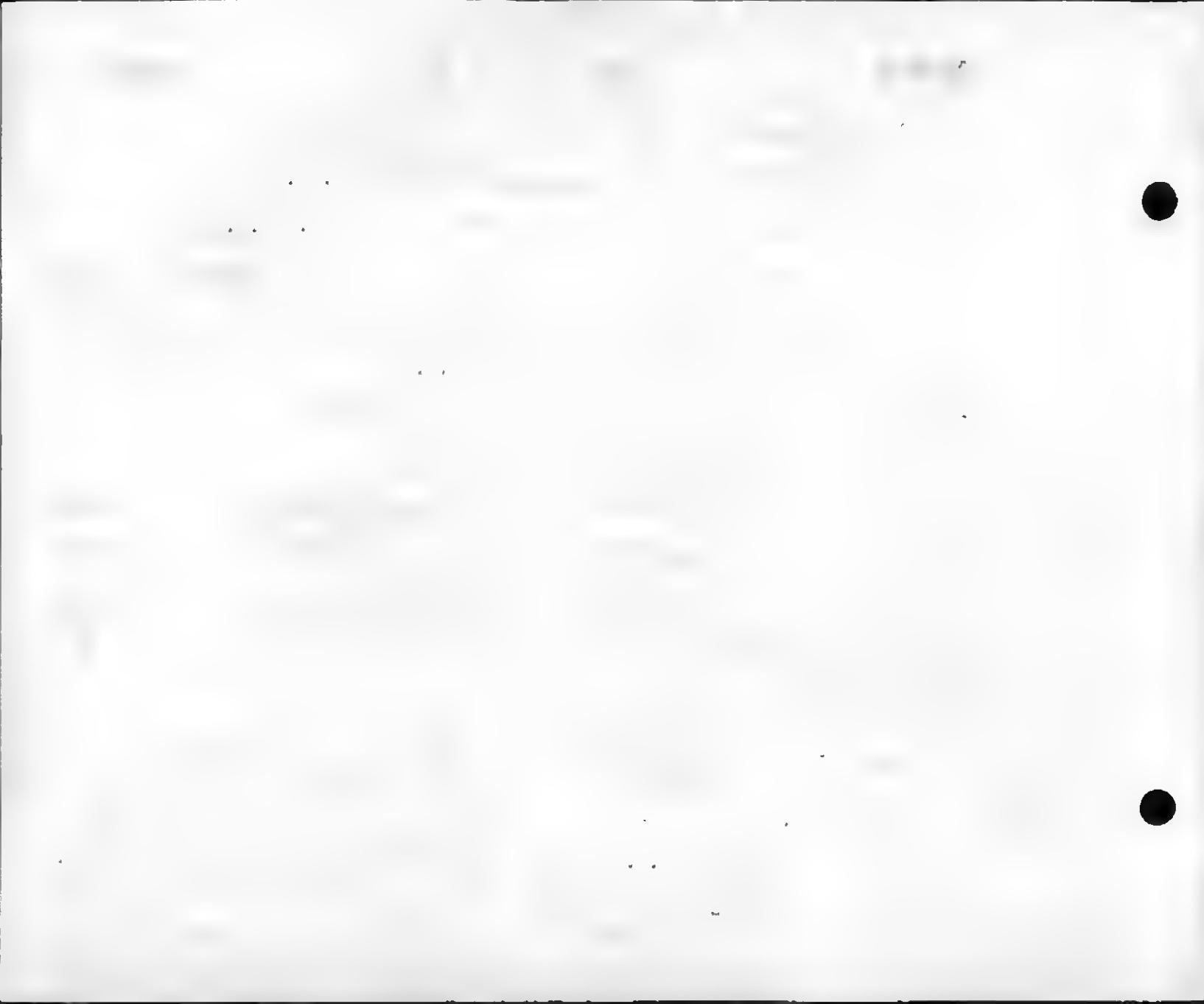
CERTIFICATE OF DEATH

14607

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 mo 22 days Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1240 Lawrence St., N.E.	
3 NAME OF DECEASED (Type or print) Leonard		First Leonard	Middle
4 DATE OF DEATH 10/24/1966	Month 10	Day 24	Year 1966
5 SEX M	6. COLOR OR RACE M	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 9/4/1898
8. AGE (In years at 1st birthday) 68 yrs		9. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY S.C.	
11 BIRTHPLACE (County & State or foreign country) S.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Mack		14. MOTHER'S MAIDEN NAME Lulu McDowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 094-03-4484	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		b. Gastrointestinal hemorrhage and bilateral bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 4 days 1 day	
(b) DUE TO Carcinoma of the liver with metastases		unknown	
(c) DUE TO Cirrhosis of the liver		1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Porto-caval anastomosis, 4/66		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/21 , 1966, to 10/24/1966 , that <input type="checkbox"/> (we) last saw the deceased alive on 10/24/1966 , and that death occurred at 5:00PM , from causes and on the date stated above.		22b. DATE SIGNED 10/24/66	
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct-27-1966	23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Memorial Cemetery
24. FUNERAL DIRECTOR <i>John T. Phillips</i>		ADDRESS 3015-12th & F St. N.E. 10C	25a. REC'D BY REGISTRAR DATE OCT 28 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL _____ **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page _____ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page _____ should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14607

14608

1. PLACE OF DEATH
a. COUNTY

Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

41 A St
3. NAME OF DECEASED
(Type or print)

First

Middle

5. SEX

6. COLOR OR RACE

M

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

W

WIDOWED

DIVORCED

Last

9. AGE (In years
last birthday)

10. KIND OF BUSINESS OR INDUSTRY

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Austin Madison

Annie Goddard

Robert Madison Laurel Md

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO
Conditions, if any, which
gave rise to immediate cause

(b) (a), stating the underlying
cause first.

DUE TO
(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 1958 to 1966, that (I) (we) last
saw the deceased alive on 10-1-1966, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE
Dolores Pierandrei, M.D.

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF
10-6-66

24. FUNERAL DIRECTOR'S SIGNATURE
De Witt Donaldson Laurel Md

23c. NAME OF CEMETERY OR CREMATORIUM
Troy Hill Cem

23d. LOCATION (City, town or county)
Laurel Md. (State)

25a. REC'D BY REGISTRAR
DATE OCT 13 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

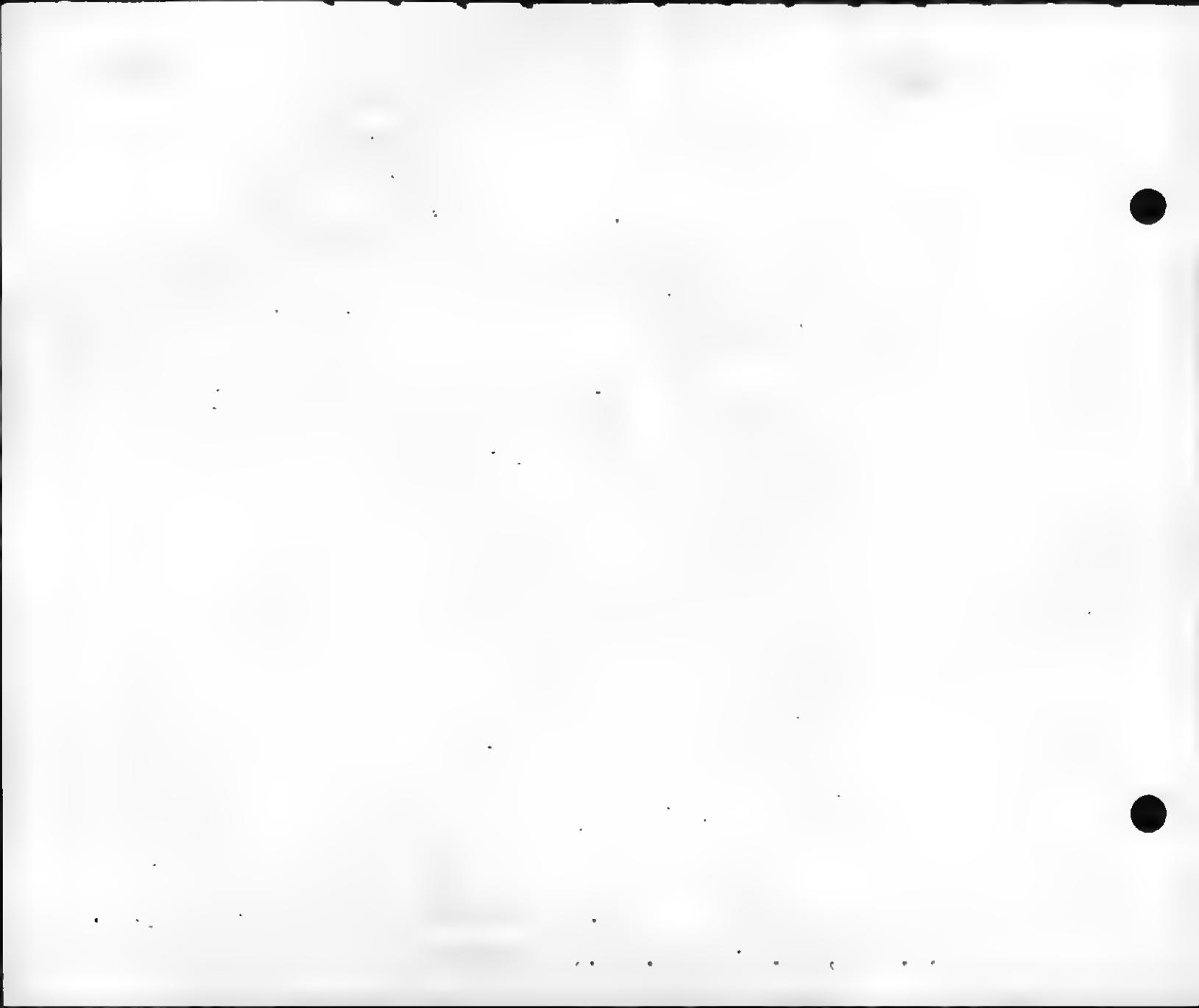
VR A15 (4)
15M 7 61



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
14608				14608																			
1. PLACE OF DEATH a. COUNTY Prince George C. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hyattsville Nursing Home				d. STREET ADDRESS 5700-31st Place																			
3. NAME OF DECEASED (Type or print) Bidelia, Margaret C. Manning				First	Middle	Last	4. DATE OF DEATH Oct. 30, 1966	Month	Day	Year													
5. SEX F				6. COLOR OR RACE W	7. MARRIED WIDOWED	8. DATE OF BIRTH SICKED OF 10-30-1898	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Lawrence Lazarus Costello				14. MOTHER'S MAIDEN NAME Julia Ann Cooney																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT JAMES MANNING 105-6th St. S.E. Husband				Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterioclerosis (c)												INTERVAL BETWEEN ONSET AND DEATH 4+ yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/1/66, 19, to Present, 19, that (we) last saw the deceased alive on 10/29/1966, and that death occurred at 9:20 A.M. from the causes and on the date stated above.												22b. DATE SIGNED 10-29-66											
22a. SIGNATURE George L. Steward				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 2390 Glenmont Circle, Bethesda, Md.															
22c. PHYSICIAN'S NAME (Type)				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								23b. DATE THEREOF 11/2/1966				23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cem				23d. LOCATION (City, town or county) Bladensburg, Md.			
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc. 317 Pa. Ave., SE WashDC				25a. REC'D BY REGISTRAR Charles Judge								25b. REGISTRAR'S SIGNATURE											
25b. REGISTRAR'S SIGNATURE Charles Judge				DATE NOV 2 1966																			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14609

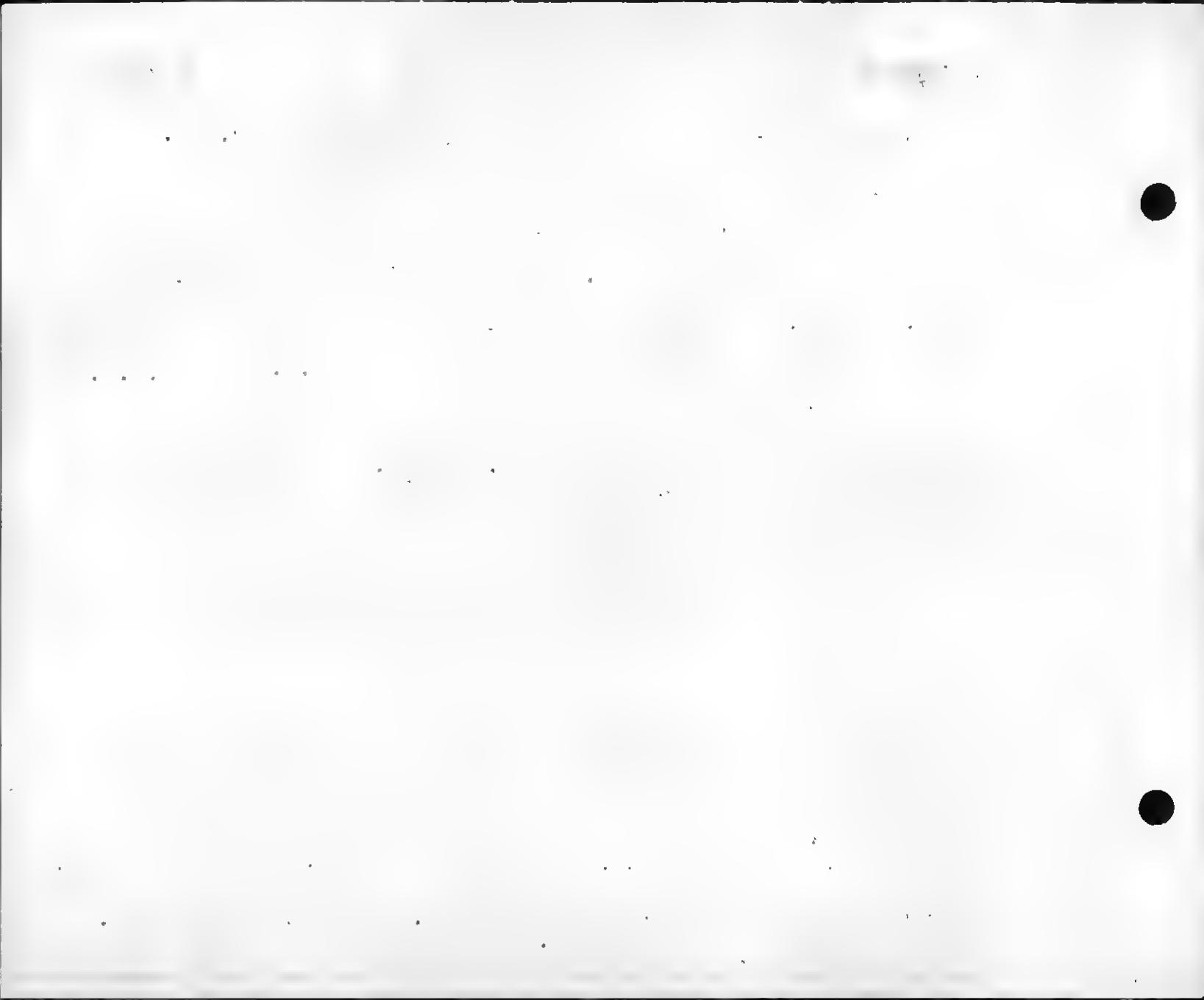
CERTIFICATE OF DEATH

14610

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Charles P. Marcellino		4. DATE OF DEATH Month Oct. 8 1966	Month Year Doy Year
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED Never Married Widowed Divorced X	8. DATE OF BIRTH 12-26-07
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR Shoe Repairer	
13. FATHER'S NAME Vincent Marcellino		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Salvatine Scaletta	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leona E. Marcellino (above address)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Shock		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and the underlying cause (c) 400		DUE TO GI bleeding	
		DUE TO Peptic Ulcer	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg, etc.) 10-8 66
21. I certify that (I) (this hospital) attended the deceased from 9-26 , 19 66 , to 10-8 , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 10-8 66 M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE A. Clark Holmes, M.D.		22b. DATE SIGNED 2-25A 10/8/66	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS 4108 Pratt St., Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL Specified Burial		23b. DATE THEREOF 10/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland	25a. REC'D BY REGISTRAR DATE OCT 13 1966
			25b. REGISTRAR'S SIGNATURE J. Clark Holmes, Judge



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

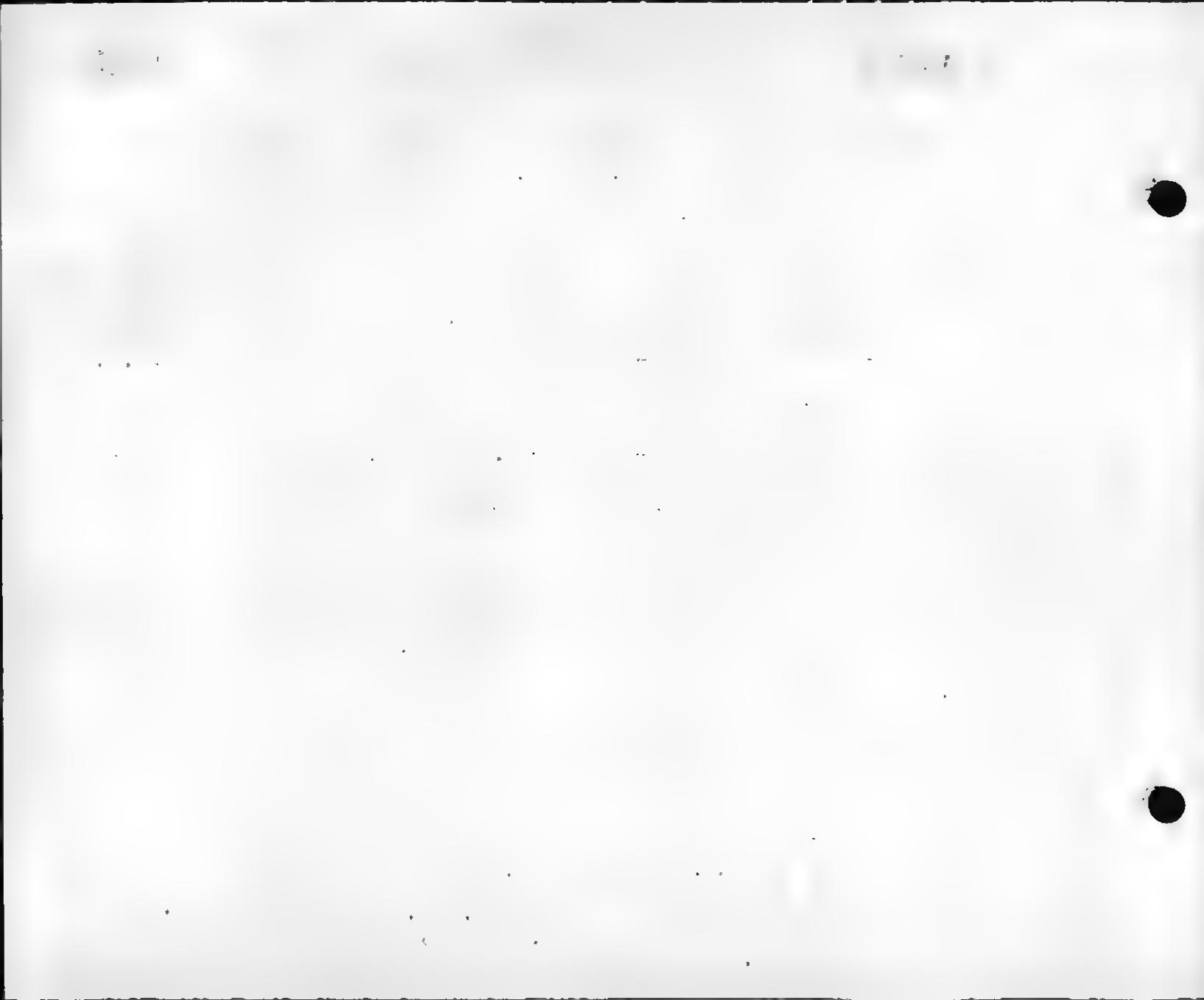
14610

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14611

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
Prince George's MARYLAND		Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr. 15 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 6904 Vallery Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Regina			Narks
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Female White			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
-		-	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Frank Marks		Mary Theresa Hooven	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Albert F. Marks (above address) (Father)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right cerebral necrosis DUE TO Infection by Proteus Vulgaris Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) From septicemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
7680			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED 10-13-66	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat. Cem.		23d. LOCATION (City, town or county) Arlington, Va. (State)	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. ADDRESS Mt. Rainier, 25b. REC'D BY REGISTRAR Maryland	
		25b. REGISTRAR'S SIGNATURE DATE OCT 20 1966 <i>Charles Judge</i>	

434



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14611 14612

1. PLACE OF DEATH
a. COUNTY Prince George MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 2 yrs
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 404 Marshall St Apt F

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md
b. COUNTY P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 16.1
d. STREET ADDRESS 404 Marshall St

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
(Type or print) Edna Ruth McCabe Oct 4 1966

5. SEX F 6. COLOR OR RACE W 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH May 10 1905 9. AGE (In years last birthday) 61 yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Name
11. BIRTHPLACE (State or foreign country) Broadcrees Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Mc Key 14. MOTHER'S MAIDEN NAME Mary M. Young
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 17. INFORMANT Address Amy M. Berger 160 Prospect St
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410 X Bilateral pulmonary edema, Severe
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Mitral Stenosis - Rheumatic Valvulitis Years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?
YES NO INTERVAL BETWEEN ONSET AND DEATH Hours

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. While at work Not White at work 19

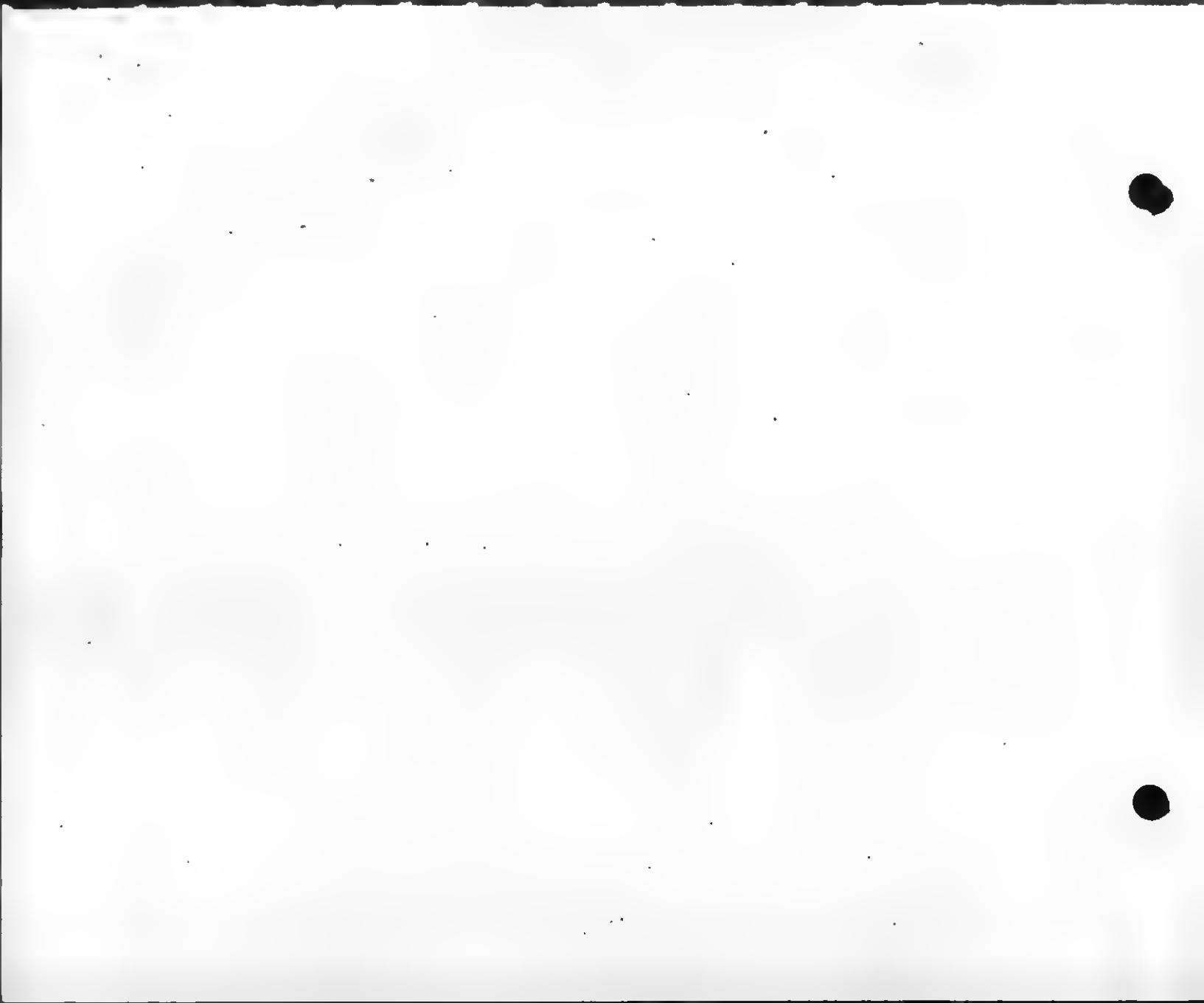
21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner
CHIEF MEDICAL EXAMINER 10-446 DATE SIGNED
M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
EXAMINER'S NAME (Type) DAYTON O'WATKINS ADDRESS (Street, city, town, or county) Beadensburg Md

22. ACTUAL SIGNATURE DAYTON O'WATKINS 23. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS (Street, city, town, or county) Gate of Heaven Cem Wheaton Md

24. FUNERAL DIRECTOR ADDRESS DeWitt Donaldson Laurel Md

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE OCT 13 1966 J. J. Judge

25. VR AISM (5) 5M 1/65



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and file any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14613
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)								
Prince George MARYLAND				a. STATE Md.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY Prince George								
Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
c. LENGTH OF STAY IN lb				d. STREET ADDRESS Hyattsville								
1 Hr.				4102 Nicholson St.,								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
Prince George				10 15 19 66								
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month	Day	Year					
William		Franklin	McLean	Feb.	13	1899	67 yrs.					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 1 YEAR Hours	13. IF UNDER 24 HRS Min.			
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	Feb. 13, 1899	67 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				
Electrical inspector				Federal Government				Pennsylvania				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY? U S A				
William F. Mc Lean				Louisa Pry								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				
yes				184 12 8053				Walter E Mc Lean Arlington Virginia				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address								
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)				Heart failure								
4200 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) Arteriosclerotic heart disease								
				DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								Over 2 yrs.
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)		20f. (City or town) (County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 1-16-66								
ACTUAL SIGNATURE John Kehoe				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Summit Hill Pa.								
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/19/66		23c. NAME OF CEMETERY OR CEMETORY G A R Cemetery		23d. LOCATION (City, town or county) Summit Hill Pa.				
24. FUNERAL DIRECTOR				ADDRESS F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 19 1966				25b. REGISTRAR'S SIGNATURE Charles Judge		
				Hyattsville, Md.		DATE						



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film 10711 10/11/66 mh

14613

CERTIFICATE OF DEATH

14614

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 18 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg		d. STREET ADDRESS Rt. 1, Box 16B	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Bertha B Mercilliott		4 DATE OF DEATH October 3 1966	Month Day Year
5. SEX Female White		6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		8. DATE OF BIRTH 7/19/172 1882	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) 84 yrs	
10c. CITIZEN OF WHAT COUNTRY? USA		11. BIRTHPLACE (County & State, or foreign country) Penns.	
13. FATHER'S NAME Andrew Jackson		14. MOTHER'S MAIDEN NAME Nella Steele	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT Warren P. Mercilliott 4001 Warner Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cadine and</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Crude</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>CVH</i>		20 days	
DUE TO (c) <i>general arteriosclerosis</i>		just	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		WAS A TROPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>10/12/1966</i> to <i>10/12/1966</i> , that (I) (we) last saw the deceased alive on <i>10/12/1966</i> , and that death occurred at <i>5:20A</i> M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Leon R. Levitsky, M.D.</i>		22b. DATE SIGNED 10-3-66	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.		22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/66	23c. NAME OF CEMETERY OR CEMINATORY Fr. Lincoln Cemetery
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd.		23d. LOCATION (City or Town) (County) (State) Prince Georges, Md.	25a. REC'D BY REGISTRAR DATE OCT 3 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles J. J.</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14614

CERTIFICATE OF DEATH

14615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb 2 hrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7107 Decatur St.	
3 NAME OF DECEASED (Type or print) Margaret		First P.	Middle Midgley
4 DATE OF DEATH October 22, 1966	Month October	Day 22	Year 1966
5 SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 10/17/09		9. AGE (In years last birthday) 57 yrs.	
10a USUAL OCCUPATION (Give kind of work done Bring most of working life, even if retired) Bookkeeper		10b KIND OF BUSINESS OR INDUSTRY Union Trust Co.	
11 BIRTHPLACE (County & State, or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph Tartone		14. MOTHER'S MAIDEN NAME Josephine Labriola	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 086 12 6947	
17 INFORMANT Richard Peter Midgley		Address Same as #2 (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i>		INTERNAL BETWEEN ONSET AND DEATH <i>45-55 min</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO <i>Acute Myocardial Infarction</i>		7 1/2 hrs.	
(c) DUE TO <i>Arteriosclerotic Heart Disease</i>		1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October 22, 1966 , to Oct. 22, 1966 , that (I) (we) last saw the deceased alive on October 22, 1966 , and that death occurred at 1:15 P.M. from causes and on the date stated above. AM		21b. DATE SIGNED 22 Oct 66	
22a. SIGNATURE <i>Thomas G. Maloney</i>		22b. ADDRESS 4814 71st Ave., Landover Hills, Md.	22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 10/25/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
24. FUNERAL DIRECTOR ADDRESS <i>F. Gasch's Sons Hyattsville, Md.</i>		23d. LOCATION (City or Town) Arlington	(County) Arlington
		25a. REC'D BY REGISTRAR DATE OCT 26 1966	(State) Va.
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Prince George</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Virginia</i>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Virginia</i>						b. COUNTY <i>Prince George</i>																	
c. LENGTH OF STAY IN 1b <i>16 days</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>5617 Kenmore Street</i>						d. STREET ADDRESS <i>5617 Kenmore St</i>																	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) <i>Samuel William E. Miers</i>			First	Middle	Last	4. DATE OF DEATH <i>Oct 17 1966</i>	Month	Day	Year														
5. SEX <i>M</i>			6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>4 Oct 1908</i>	9. AGE (in years) <i>58</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Routine</i>	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Samuel William Miers</i>	14. MOTHER'S MAIDEN NAME <i>ADA Kriupp</i>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>378-57-0666</i>			17. INFORMANT <i>Central Mortuary</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
DUE TO (b) <i>falling</i>			DUE TO (c) <i>gun shot wound</i>			INTERVAL BETWEEN ONSET AND DEATH <i>in bed</i>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>gun shot wound of head</i>														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>gun shot wound of head</i>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>gun shot wound of head</i>			20c. TIME OF INJURY, Month, Day, Year Hour a.m. <i>12 AM</i> p.m. <i>4 PM</i> 19 <i>66</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>			20f. (City or town) <i>Bladensburg</i>	(County) <i>Md.</i>	(State) <i>Md.</i>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22. ACTUAL SIGNATURE <i>Samuel William Miers</i>			23. DATE SIGNED <i>10-24-66</i>																	
EXAMINER'S NAME (Type) <i>D. J. T. C. L. M. T. R. M.</i>			24. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			25. DATE THEREOF <i>7 Oct 1966</i>			26. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Ft. Lincoln Cem</i>			27. LOCATION (City, town or county) <i>Bladensburg, Md.</i>											
28. FUNERAL DIRECTOR <i>W. W. Chambers Co.</i>			29. REC'D BY REGISTRAR <i>Charles Judge</i>			30. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			31. DATE <i>OCT 10 1966</i>														



1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm \$ may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 14616 Film 3752 11/1/66 m

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14617

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights 11/1/66	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4803 Rue St. S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leon Woodrow Myers	First Middle Last	4. DATE OF DEATH 10 Month 30 Day 19 Year 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 March 1913
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		11. KIND OF BUSINESS OR INDUSTRY D.G.S. Warehouse	9. AGE (In years, last birthday) 53 yrs
13. FATHER'S NAME EDWARD MYERS		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO 579073896	17. INFORMANT SUSIE C. MYERS
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure		Address SAME AS #2	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c)		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 or work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county) 10-31-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2 Nov 1966	23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN	23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND.
24. FUNERAL DIRECTOR W.W. Chambers Co., Riverdale, Md.	ADDRESS	25a. REC'D BY REG STRR NOV 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

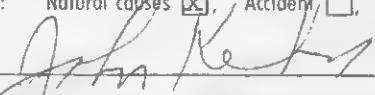
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit to file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14618

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY Maryland Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 407 65th Street					
3 NAME OF DECEASED (Type or print) Julia		First	Middle				
4 DATE OF DEATH 10 25 1966		Month	Day				
5 SEX Female		6 CO. OR RACE Negro	7 MARRIED WIDOWED	8 DATE OF BIRTH 25 Feb. 1888	9 AGE (In years lost birthday) 78 yrs	10. IF UNDER 1 YEAR Months Days Hours M.n.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Prince George Co., MD USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Harley		14. MOTHER'S MAIDEN NAME Georgianna Newman		15. INFORMANT John A. Newman		Address 407-65th St., Maryland Pk, Md.	
16. SOCIAL SECURITY NO None		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 10-26-66			
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel	23d. LOCATION (City or Town) Upper Marlboro, Md.	(County) (State)		
24. FUNERAL DIRECTOR Rollins, Inc.		ADDRESS 4339 Hunt Pl., N.E.		25a. REC'D BY REGISTRAR DATE OCT 28 1966	25b. REGISTRAR'S SIGNATURE 		

1
M
FOR STATE
HEALTH DEPT.

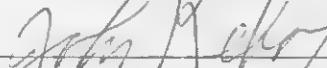
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

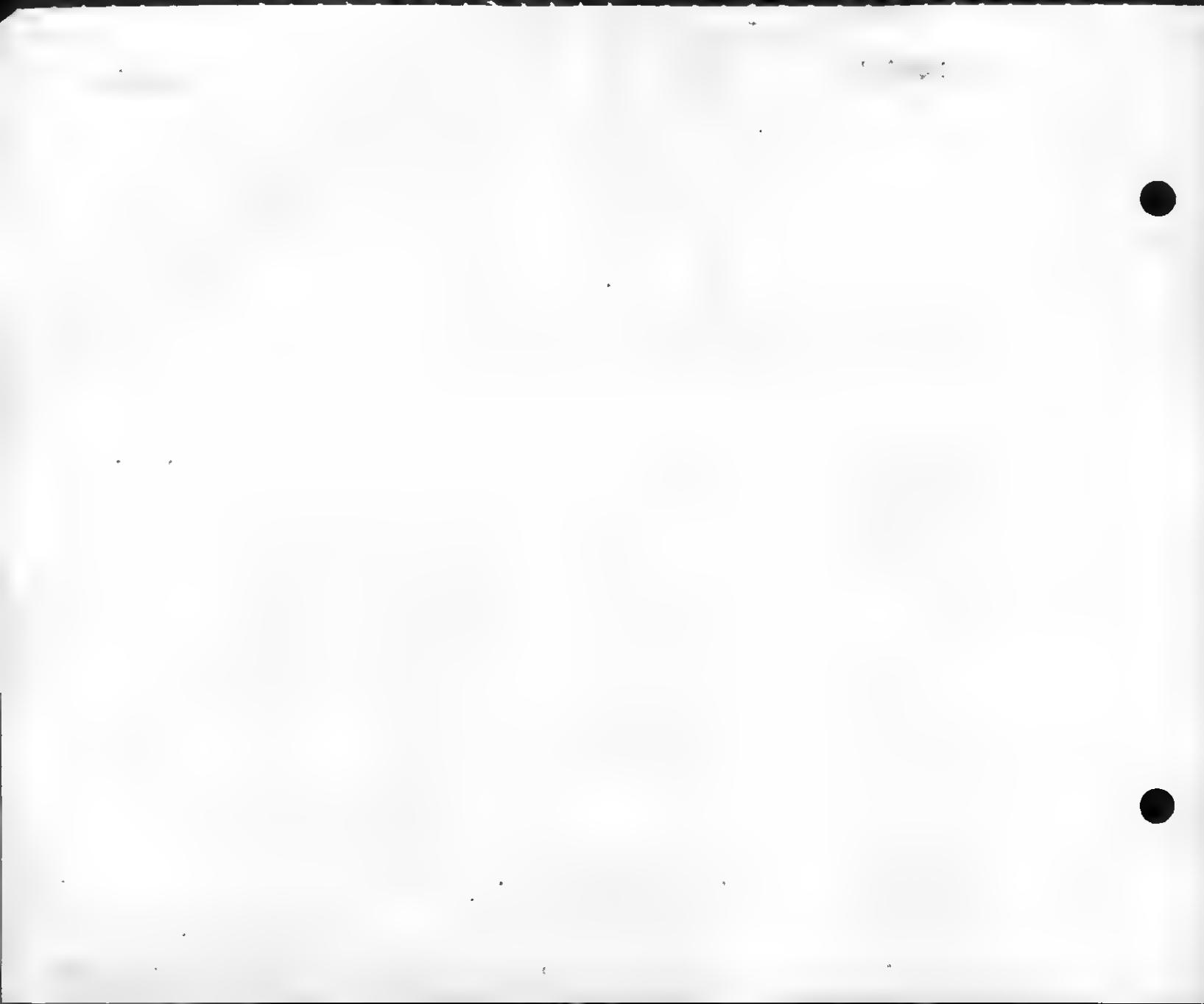
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14619

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if inst. on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 13205 Engleside Drive	
3. NAME OF DECEASED (Type or print) Walter J. Nickle		4. DATE OF DEATH 10 20 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13. FATHER'S NAME Lester B Nickle		14. MOTHER'S MAIDEN NAME Emma Klaingler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. 11	
17. INFORMANT Rosalia Nickle		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-21-66	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 25, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		ADDRESS	25a. RECEIVED BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE DATE OCT 26 1966



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film#33417466 pg

14619

CERTIFICATE OF DEATH

Jordan Oldham 14620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 9017 51st Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First Jasper	Middle G.	Last Oldham	4. DATE OF DEATH October 1 19 66	Month Month Year Day	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 4/3/07	9. AGE (in years last birthday) 59 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Greenbelt Town		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A						
13. FATHER'S NAME Thomas T Oldham		14. MOTHER'S MAIDEN NAME Florence Oveman										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217 09 6183		17. INFORMANT Lillian P Oldham		Address College Park, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Bacilleopneumonia				INTERVAL BETWEEN ONSET AND DEATH 1 month						
(b) DUE TO		Coccioidoma of Lung										
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 30</u> , 1966, to <u>Oct 1</u> , 1966, that (I) (we) last saw the deceased alive on <u>Aug 30</u> 1966, and that death occurred at 9:15 A.M. from causes and on the date stated above.												
22a. SIGNATURE George William Ware		ATTENDING M.D. a.m. <input checked="" type="checkbox"/> MED. PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/1/66								
22c. PHYSICIAN'S NAME (Type) George William Ware, M.D.		22d. ADDRESS 1835 Eye St., N.W., Washington, D.C.										
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 4, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery		23d. LOCATION (City or Town) Colmar Manor Pro Geo Md.		(County) (State)				
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

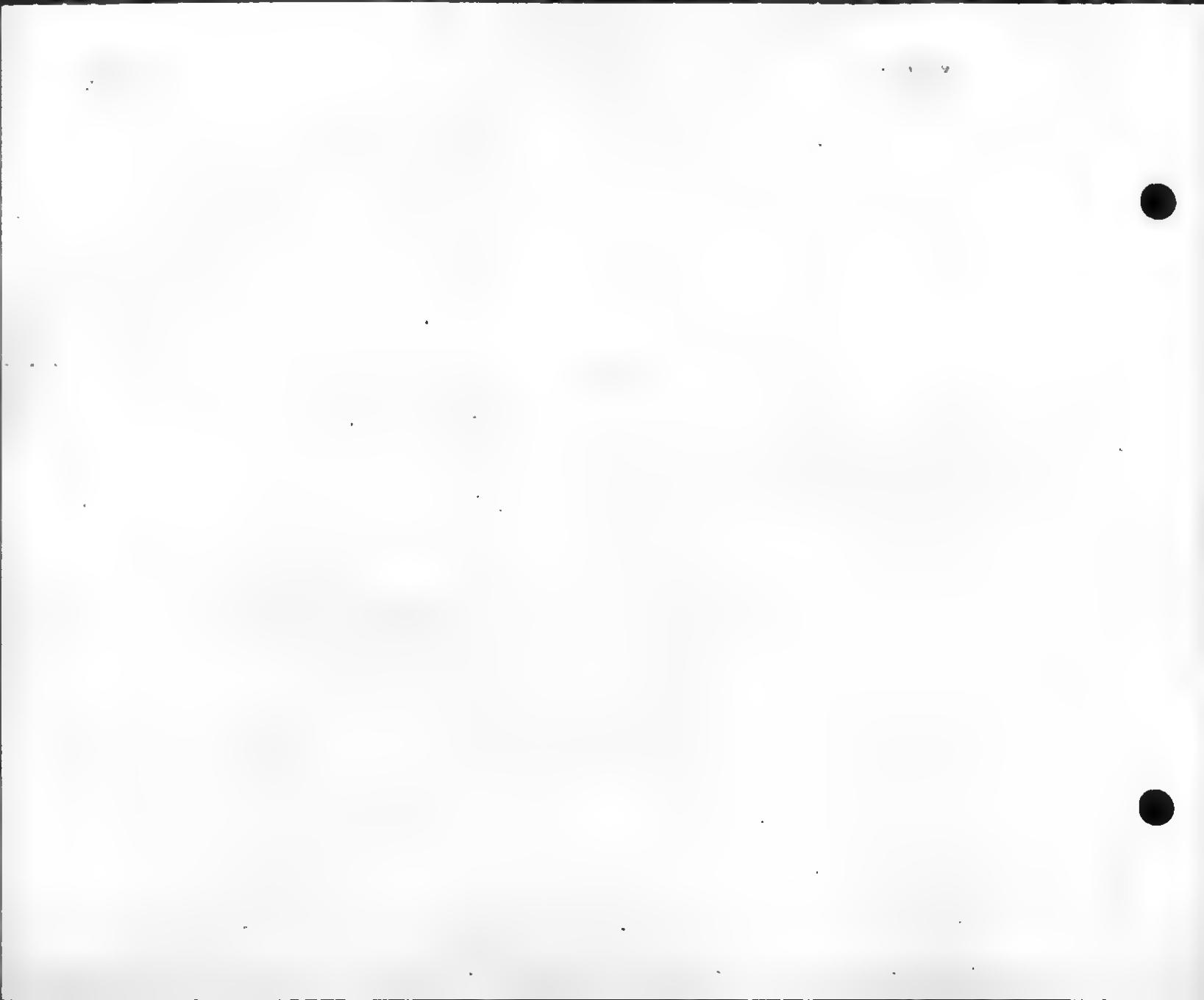
14621

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Washington, D.C.</i> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN lb <i>2 years</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll Manor</i>		e. STREET ADDRESS <i>2852 Ontario Rd., N.W.</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <i>Loretta</i>	Middle <i>H. H.</i>	Last <i>O'Reilly</i>						
4. DATE OF DEATH Month <i>Oct.</i>	Month <i>21</i>	Day <i>1966</i>	Year						
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 16, 1881</i>						
9. AGE (In years lost birthday) <i>84 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Registered nurse</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Nursing</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Cochran, Ontario, Canada</i>						
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Michael Doyle</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Pillow</i>	Address <i>4922 2nd Street, N.E.</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>612 715</i>	17. INFORMANT <i>Sr. M. Luke, O.CARM. Hyattsville, Md.</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>44.3X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO <i>Cerebrovascular hemorrhage</i> <i>Hypertension heart disease</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>James</i>	20f. (City or town) <i>Oct. 21</i>	(County) <i>Pittsburgh</i>	(State) <i>Pennsylvania</i>
21. I certify that (I) (this hospital) attended the deceased from <i>James</i> , 1966 to <i>Oct. 21</i> , 1966 that (I) (we) last saw the deceased alive on <i>Oct. 20</i> , 1966, and that death occurred at <i>James</i> M, from causes and on the date stated above.					22a. SIGNATURE <i>Thomas F. Collins</i>	M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>10-21-66</i>		
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>364 "H" St NE</i>			23a. BURIAL CREMATION, REMOVAL (Specify) <i>Trans-burial</i>	23b. DATE THEREOF <i>Oct. 25, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Mary's Cemetery</i>	23d. LOCATION (City or Town) <i>Pittsburgh, Pennsylvania</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>	25a. ADDRESS <i>Johns Hopkins 8434 Georgia Avenue Silver Spring, Md.</i>			25b. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G301 10/17/66 mm

14621

Item 2 Film G381 10/16/66 mm

CERTIFICATE OF DEATH

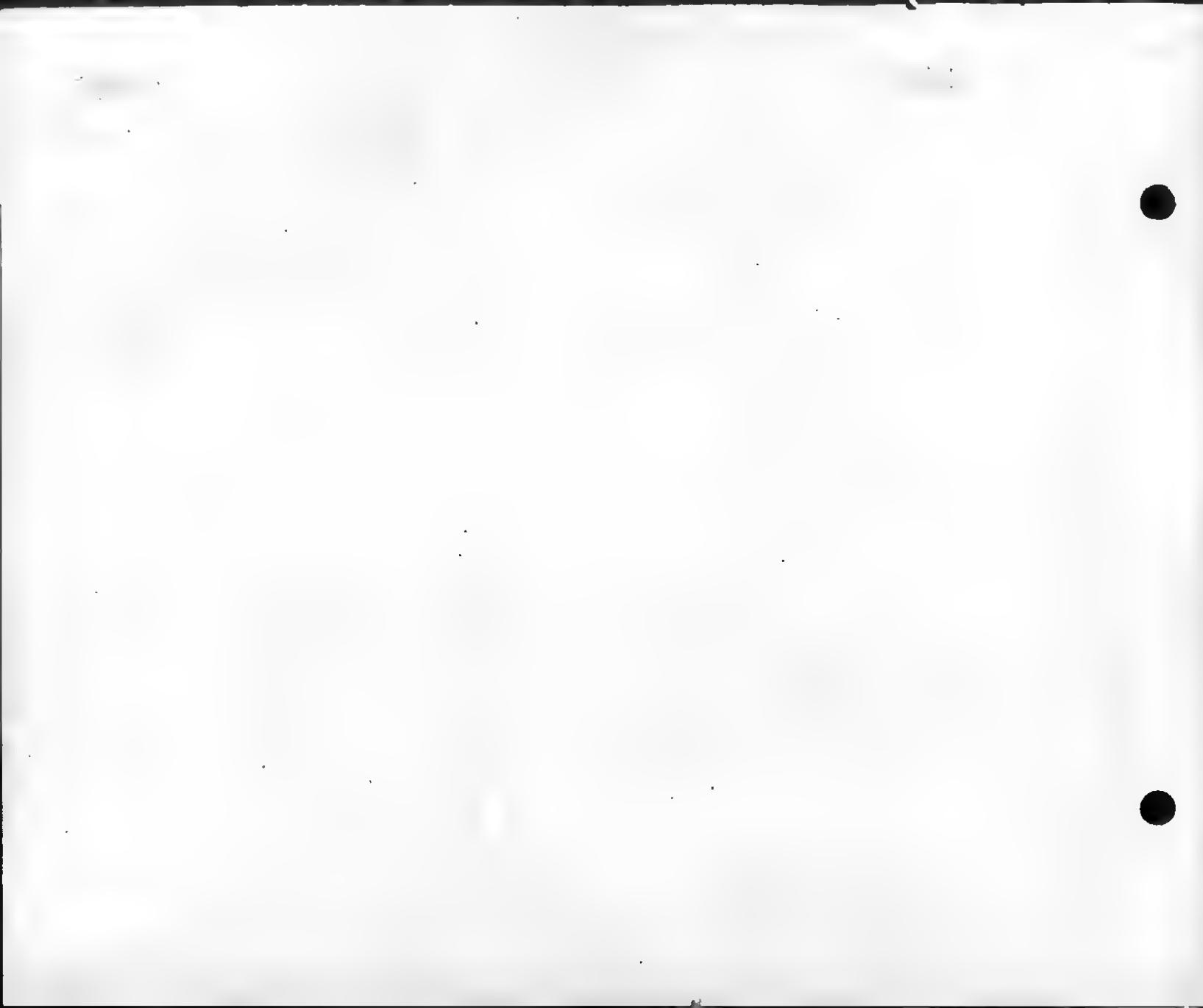
14622

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 700 - 6 th Ave. 9104 Good Luck Rd.		
3. NAME OF DECEASED (Type or print) First Eliza Middle P Last Pace		4. DATE OF DEATH Month October Day 8, 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Monie Jones		14. MOTHER'S MARRIED NAME Maggie Herdon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs Elsie Young Daughter		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacloph pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 332.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Cerebral Thrombosis</u> <u>11 days</u> stating the underlying cause (c) <u>Generalized Arterio scleriosis zyns</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Suitland</u> (County) <u>Prince George's</u> (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1966, to <u>Oct. 8</u> , 1966, that (I) (we) last saw the deceased alive on <u>Oct. 8, 1966</u> , and that death occurred at <u>1:05 P.M.</u> from causes and on the date stated above.				22b. DATE SIGNED <u>10/15/66</u>
22a. SIGNATURE <u>Germann L. Comeau</u>		ATTENDING MED. PHYS. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <u>3503 Penny St. Suitland, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Germann L. Comeau</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10.11.66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Md.
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 300.4th st N E	25a. REC'D BY REGISTRAR OCT 1 1966	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14622

CERTIFICATE OF DEATH

14623

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. LENGTH OF STAY IN 1b D. O. A.		d. STREET ADDRESS 4504 Beechwood Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARIION	Middle W.	Last PARKER
4. DATE OF DEATH	Month 10	Day - 8	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1907
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adm. Agr. Res.	10b. KIND OF BUSINESS OR INDUSTRY U.S. Goverment	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME John C. Parker	14. MOTHER'S MAIDEN NAME Verta Parsons		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO	16. SOCIAL SECURITY NO. 217 44 0414	17. INFORMANT Mrs. Katherine H. Parker	Address Same as #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST			
INTERVAL BETWEEN ONSET AND DEATH 1hr			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) CORONARY THROMBOSIS, ACUTE 1hr	
DUE TO (c) CHRONIC CORONARY INSUFFICIENCY 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from June, 1964, to 10/8, 1966, that (I) (we) last saw the deceased alive on 10-8 1966, and that death occurred at 343 M, from the causes and on the date stated above.			
22a. SIGNATURE Norman J. Comeau		22b. DATE SIGNED 10/8/66	
22c. PHYSICIAN'S NAME (Type) Norman J. Comeau	22d. ADDRESS 3503 Penny St MT Rainier md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Parson's	23d. LOCATION (City, town or county) (State) Salisbury Md.
24. FUNERAL DIRECTOR Francis Gasch; Sons Hyattsville, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE OCT 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14623

CERTIFICATE OF DEATH

14624

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Princes George's, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Princes Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Island Memorial 4408 University Rd, 4711 Tecumseh St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Pt, Md.	
3. NAME OF DECEASED (Type or print) GLAZYS READ, PATRICK		4. DATE OF DEATH Month 10 Day 23 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-12-02		9. AGE (In years last birthday) 63 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistical Clerk		11. BIRTHPLACE (County & State, or foreign country) Md.	
13. FATHER'S NAME WILLIAM READ		14. MOTHER'S MAIDEN NAME MARGARET CISELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579 05 4121	
17. INFORMANT Record Office, 4408 University Rd., Riverdale, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 40 Hrs	
DUE TO (b) Myocardial Infarction complicated by Ventricular Fibrillation			
DUE TO (c) Acute cerebral edema			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 10/15/66
21. I certify that (I) (this hospital) attended the deceased from 10/13/66 to 10/22/66, and that death occurred at 10:20 p.m. M. from causes and on the date stated above.		20f. (City or town) (County) (State) 10/22/66	
22a. SIGNATURE W. E. Fienn		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-23-66
22c. PHYSICIAN'S NAME (Type) W. E. Fienn		22d. ADDRESS College Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-27-66	23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
ADDRESS		25a. RECD BY REGISTRAR J. Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE OCT 26 1966			



FOR STATE
HEALTH DEPT.

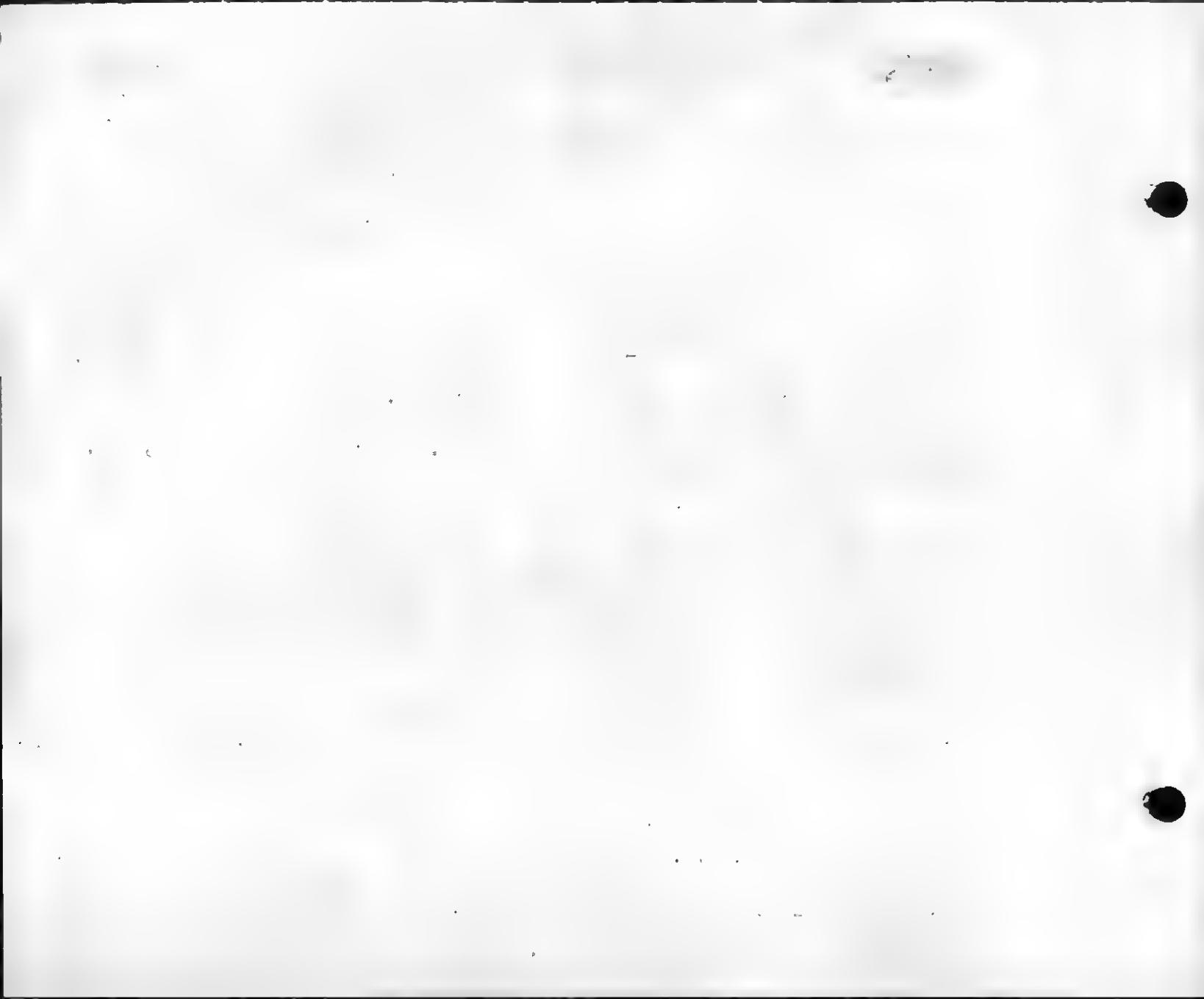
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14624 11625

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, write address before admission) a. STATE		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Prince George	
Riverdale		2 days		Mt. Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Leland Memorial Hospital		d. STREET ADDRESS		3338 Chauncy Place	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day Year
Richard Wayne Patrick				Patrick	10	8	19 66
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4 April 1949	17 yrs.	Months Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)	
Student			-			West Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?	
Creed W Patrick			Marie V. Akers			U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT	
NO						Creed W. Patrick Mt Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) left subdural hematoma							
DUE TO Right and left intra cerebral hemorrhages							
Conditions, if any, which gave rise to immediate cause (a), stating the (b) Basilar skull fracture							
DUE TO Trauma-motorcycle accident							
underlying cause last. (c) 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
Trown from motorcycle							
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, offc, bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a.m.		While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		6600 Block Bellcrest Rd.	Prince George	Md.	
3:30 pm. 10 6 19 66							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
John Kehoe, M.D. Riverdale		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county) 22. DATE SIGNED							
10-9-66							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Burial		10-11-1966		Allison Cemetery		Allisonia, Virginia	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Nalleys Funeral Home		Mt Rainier, Md		DATE OCT 13 1966		Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

The death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be signed by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation, or removal and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the

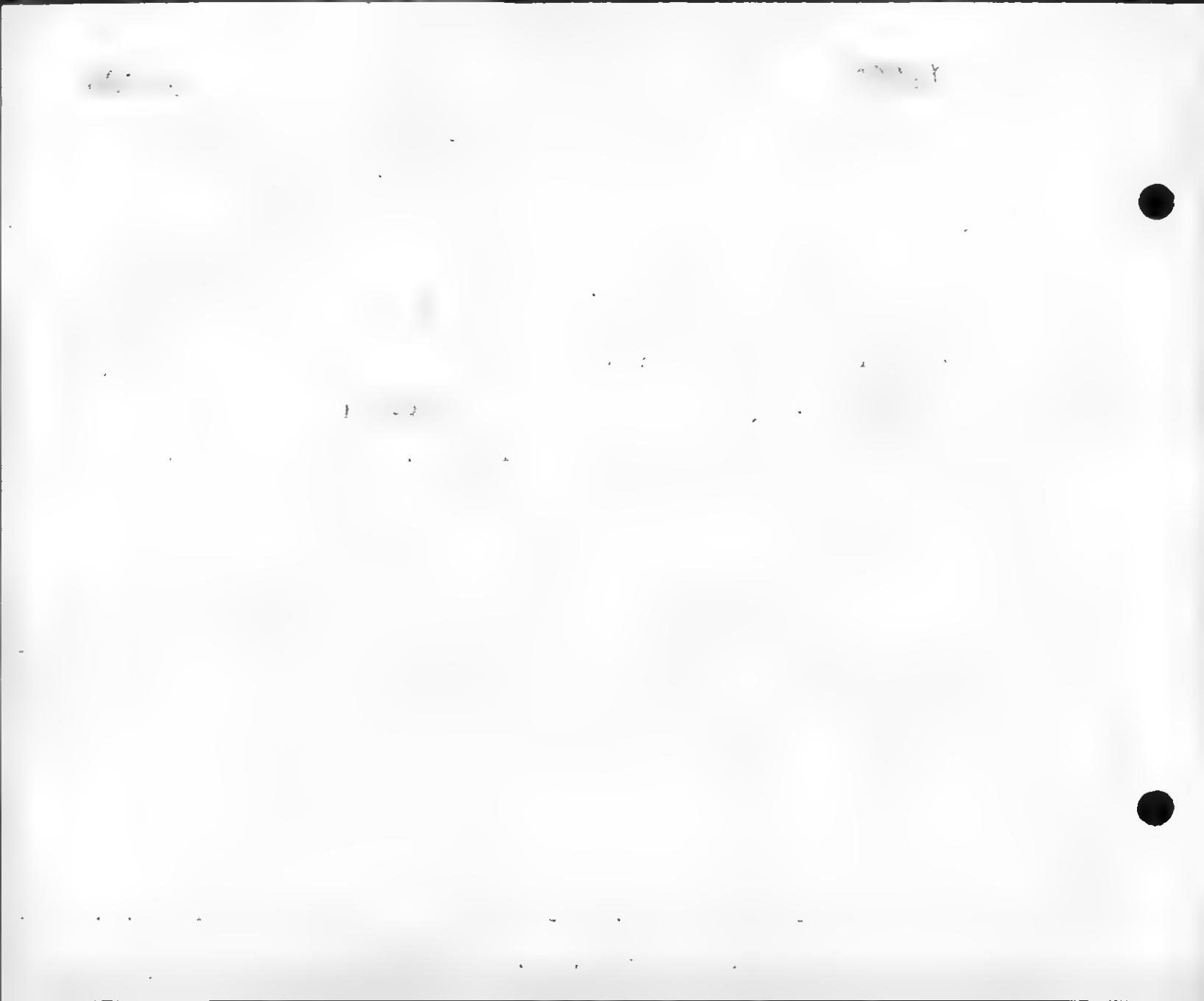
VR A15 (4)
20 M 1/66

14625

CERTIFICATE OF DEATH

14626

1 PLACE OF DEATH a. COUNTY Prince Georges			MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		
b. CTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Heights		e. STATE Maryland		b. COUNTY Prince Georges
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 5402 Emerson Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Carrie		First Amber	Middle Pease	4 DATE OF DEATH 10 8 19 66	Month	Day	Year	
S. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-95	9 AGE (In years last birthday) 71 yrs.	10. FUNDER 1 YEAR Months Days Hours Min	11. BIRTHPLACE (County & State, or foreign country) Maine		
10a. USLA. OCCUPATION (Give kind of work done during past 6 months, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles A. Bragg			14. MOTHER'S MAIDEN NAME Ida Cochranck					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	17. INFORMANT William H. Pease Same as #2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			CORONARY OCCLUSION			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE		
4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			3 YEARS		
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 2 - c, 19 63, to present, 19 , that (I) (we) los saw the deceased alive on 7 23 19 66, and that death occurred at 1 A.M., from causes and on the date stated above								
22a. SIGNATURE <i>C. Horner</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-8-66					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	23d. LOCATION (City or Town) Colmar Manor P.G. Md.			(County)	(State)
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		ADDRESS		25a. RECD BY REGISTRAR DATE OCT 11 1966	25b. REGISTRAR'S SIGNATURE <i>Levitt Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

(M)

14626

CERTIFICATE OF DEATH

14627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara		First: _____	Middle: _____
4. DATE OF DEATH Phillips		Month: October	Day: 29, Year: 1966
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1939
9. AGE (In years last birthday) 27 yrs		10. IF UNDER 1 YEAR Months: 0 Days: 0 Hours: 0 Min: 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel James		14. MOTHER'S MAIDEN NAME Arzalia Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT		Address Arzalia Butler, 428 O.St. Wash, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured berry aneurism DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) A.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to Oct. 29, 1966, that (I) (we) last saw the deceased alive on Oct. 29, 1966, and that death occurred at 8:15M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. G. Raven</i>		22b. DATE SIGNED A.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-4-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat'l. Cem., Arlington, Va.
24. FUNERAL DIRECTOR Frazier Funeral Home 389 P.I. on N.W.		25a. LOCATION (City or Town) (County) (State) DATE NOV 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
FOR STATE
HEALTH DEPT.

14627

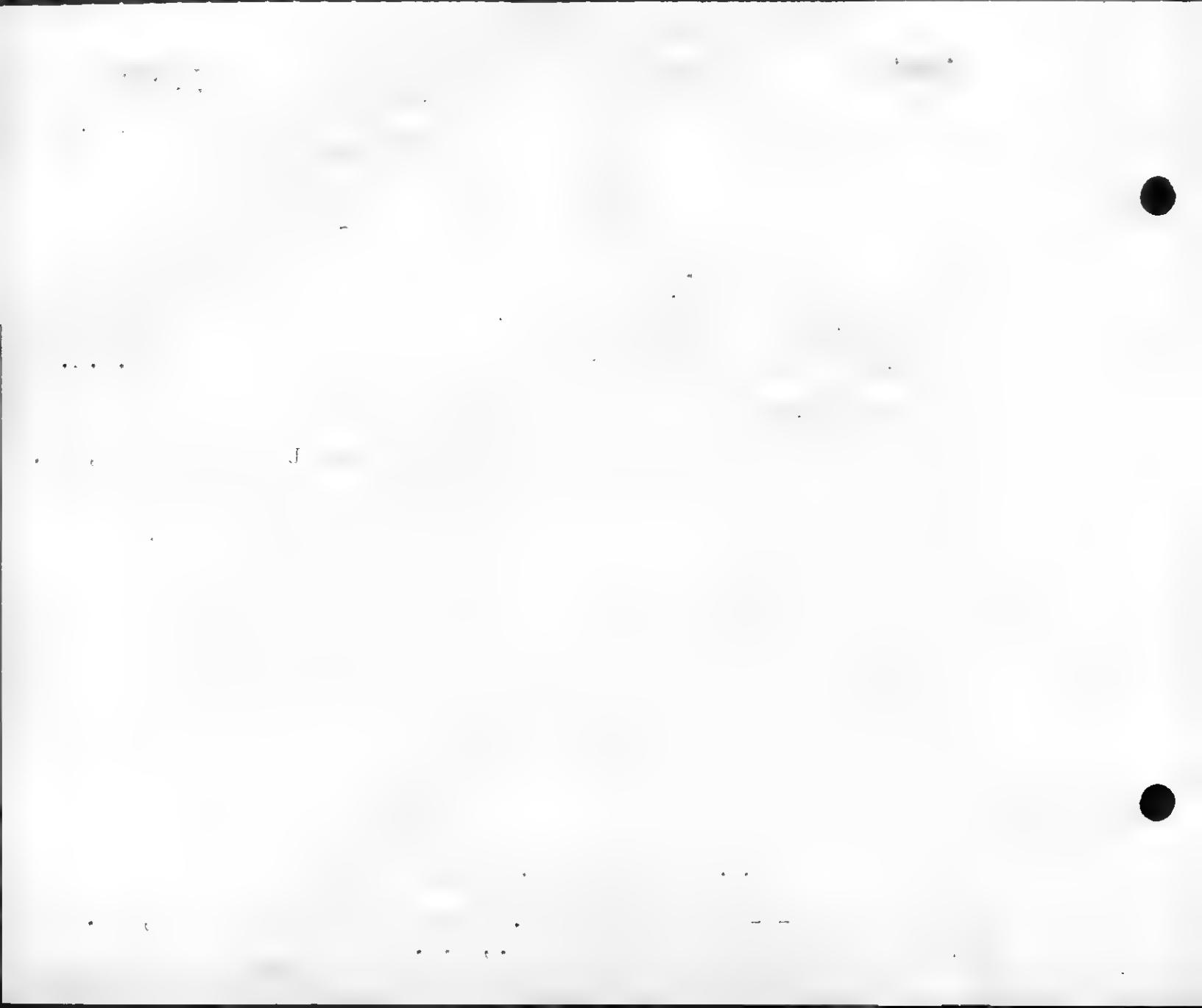
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14628

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN TB 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS General Delivery	
3. NAME OF DECEASED (Type or print) Katie Mildred		4. DATE OF DEATH 10 28 19 66	Month Day Year
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Henry Pinkney		14. MOTHER'S MAIDEN NAME Minnie Hawkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Carlos Pinkney		Address Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left frontal parietotemporal subdural</u> 9.36.9 DUE TO <u>hematoma with compression of underlying cortex.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) unknown	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown unknown ¹⁹		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>John Kehoe</u> M.D.	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10-30-66	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 11-2-66	23c. NAME OF CEMETERY OR CREMATORIAL Union Meth. Cemetery	23d. LOCATION (City or Town) (County) (State) Upper Marlboro, Md.
24. FUNERAL DIRECTOR Rollins Funeral Home	ADDRESS 4339 Hunt Pl., N.E.	25a. REC'D BY REGISTRAR DATE NOV 3 1966	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14628

CERTIFICATE OF DEATH

14629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			b. COUNTY Prince George's		
c. LENGTH OF STAY IN 1b 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5700 16th Avenue		
3 NAME OF DECEASED (Type or print) Everett R			4. DATE OF DEATH October 20 1966	Month	Day
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 4-24-1914	9. AGE (In years last birthday) 52 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. JS/JAI OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (County & State, or foreign country) Virginia		
10b. KIND OF BUSINESS OR INDUSTRY grayhound Co.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William F. Poindexter			14. MOTHER'S MAIDEN NAME Mary Glass		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. Unk.		
17. INFORMANT Sheridan, Ranson & Smith Funeral Home			18. ADDRESS Krent Store, Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right coronary artery Occlusion with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypocondrial dysfunction DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-4-66, to 10-20-66, that (I) (we) last saw the deceased alive on 10-19-66, and that death occurred at 2:00 A.M. from causes and on the date stated above					
22a. SIGNATURE Irvin M. Grassgreen		22b. DATE SIGNED 10-20-66			
22c. PHYSICIAN'S NAME (Type) Dr. Irvin M. Grassgreen		22d. ADDRESS 3101 Arundel Rd., Mr. Rainier, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/66	23c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery		23d. LOCATION (City or Town) Louisa, Virginia
24. FUNERAL DIRECTOR Robert J. Murphy		25a. RECD BY REGISTRAR Murphy Funeral Home, Arlington, Va.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

14629

CERTIFICATE OF DEATH

14630

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE Maryland b. COUNTY Pro George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 5805 36th avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ilia M. Priester		4. DATE OF DEATH Oct 13, 1966-19	Month Day Year				
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1903	9. AGE (In years last birthday) 63 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept Store		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Davis		14. MOTHER'S MAIDEN NAME Eugina Black					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579-22-0033		17. INFORMANT Betty M. Parker		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Arterio myxocardia infarction		INTERVAL BETWEEN ONSET AND DEATH under			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		auricular fibrillation		1962			
DUE TO (b)		arterio elastic bent disease.		years.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 7/10, 1962 to Oct 10, 1966, that (I) (we) last saw the deceased alive on 10/10, 1966, and that death occurred at 40 M, from causes and on the date stated above.							
22a. SIGNATURE E.H. Markwood		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/14/66			
22c. PHYSICIAN'S NAME (Type) Emmett H. Markwood, M. D.		22d. ADDRESS 3208 17th Street, N. W. Washington, D. C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit		23b. DATE THEREOF 10/16/66	23c. NAME OF CEMETERY OR CREMATORIUM Fairfax Cemetery	23d. LOCATION (City or Town) Fairfax, South Carolina		(County)	(State)
24. FUNERAL DIRECTOR F. J. J. Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE OCT 17 1956	25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 303 11/27/66 mh

14630

CERTIFICATE OF DEATH

14631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's									
c. LENGTH OF STAY IN lb 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1010 64th Avenue									
3. NAME OF DECEASED (Type or print) First: Arthur Middle: P Last: Prince		4. DATE OF DEATH Month: October Day: 27 Year: 1966									
5. SEX Male Negro		6. COLOR OR RACE 7. MARRIED WIDOWED NEVER MARRIED DIVORCED XX		8. DATE OF BIRTH Nov. 4, 1937		9. AGE (in years last birthday) 29 28 yrs		10. IF UNDER 1 YEAR Months: 11 Days: 28 Hours: 0 Min: 0		11. IF UNDER 24 HRS. Months: 0 Days: 0 Hours: 0 Min: 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David Prince		14. MOTHER'S MAIDEN NAME Beatrice Colston		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT DAVID Prince Same as 2D		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5400 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO Hemorrhage		DUE TO Shock		INTERVAL BETWEEN ONSET AND DEATH Starting					
(b) DUE TO large perforating, penetrating a closed vessel		(c) DUE TO gastric ulcer									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from October 8, 1966, to October 27, 1966, that (we) last saw the deceased alive on October 27, 1966, and that death occurred at 1-45 M, from causes and on the date stated above.								22b. DATE SIGNED 10-27-66			
22a. SIGNATURE Dr. Lee Lacer		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. AM. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dr. Lee Lacer		22d. ADDRESS Prince George's Genl. Hosp., Cheverly Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-1-66		23b. DATE THEREOF 11-1-66		23c. NAME OF CEMETERY OR CREMATORIUM Harmony Cemetery		23d. LOCATION (City or Town) Highland Park Md					
24. FUNERAL DIRECTOR 45. Washington & Sons 4925 Dean Ave N.E.		ADDRESS 45. Washington & Sons 4925 Dean Ave N.E.		25a. REC'D BY REGISTRAR NOV 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

1
FOR STATE
HEALTH DEPT.

If any delay is necessary
please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral
director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be
retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department
of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

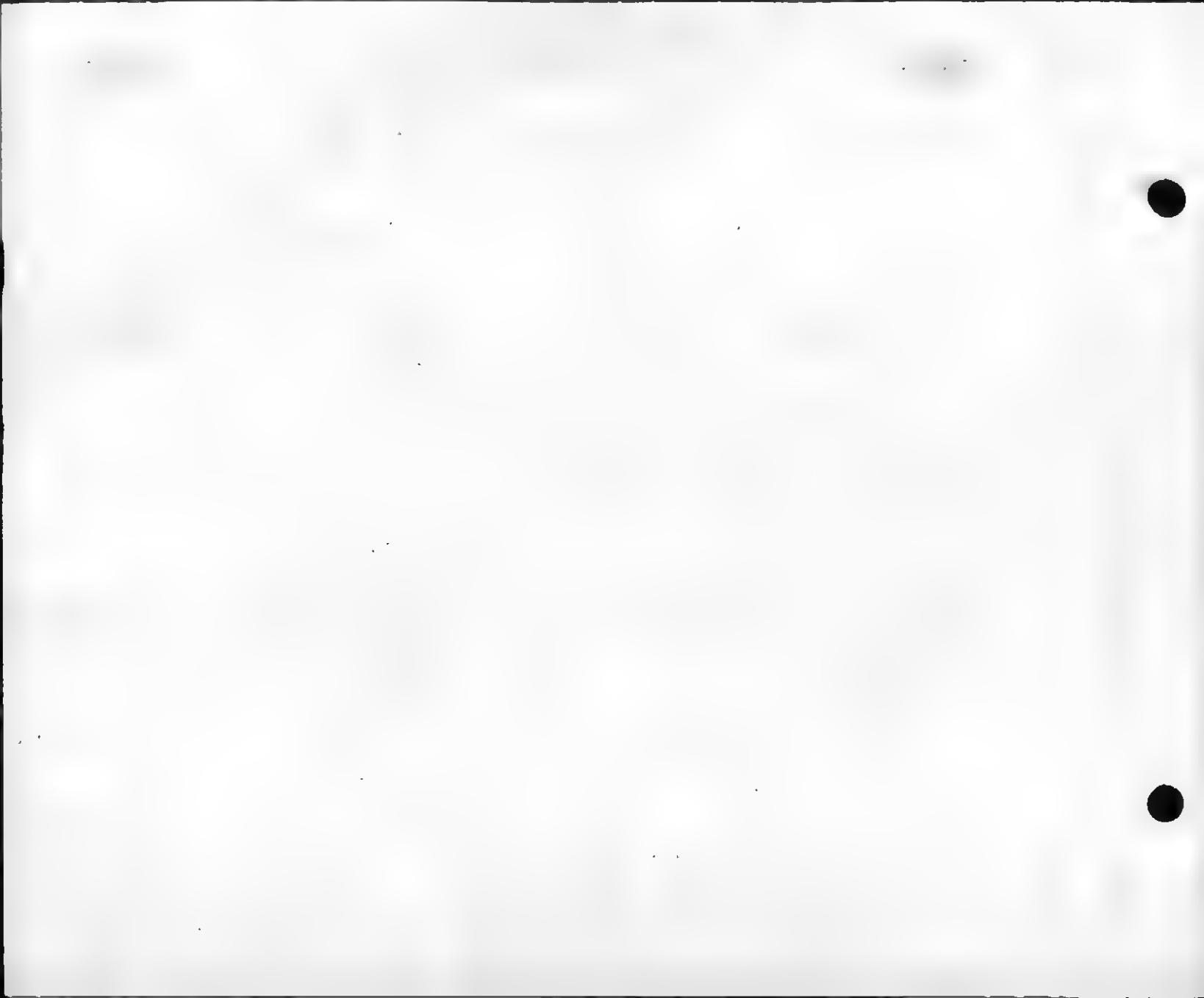
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14631

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14632

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md. b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville Minutes			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Baltimore Pike.			d. STREET ADDRESS 114080 Old Baltimore Pike		
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH 10 9 19 66		
5. SEX M Negro 6. COLOR OR RACE Albert 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 12 July 1918 9. AGE (in years last birthday) 48 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Ragsdale			14. MOTHER'S MAIDEN NAME Mary Edmondson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural and subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Depressed skull fracture-rt. temporal DUE TO (c) Blunt trauma to head PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Minutes					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Struck on head by assailant		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30 pm		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Used car junkyard, Old Balt Pike, P.G. Md.	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Keloe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10-10-66		
22. DATE SIGNED					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 10-15-66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Harmon Cemetery	
24. FUNERAL DIRECTOR John D. Wats.		25a. REC'D BY REGISTRAR Walt		25b. REGISTRAR'S SIGNATURE DATE OCT 30 1966 J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 2 hrs. 15 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 8330 Quentin St.	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month Day Year Oct. 7 1966	
5. SEX Male		6. COLOR OR RACE Cauc.	
7. MARRIED WIDOWED		8. DATE OF BIRTH Reid	
9. AGE (In years, months and days) Oct. 7, 1966		10. IF UNDER 1 YEAR Months Days Hours Min 2 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Prince George's Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Charles Reid		14. MOTHER'S M AIDEN NAME Patricia Ellen Noe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mother		18. ADDRESS as above	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital INTERVAL BETWEEN ONSET AND DEATH DUE TO 7761 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Imaturity DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-7 1966 to 10-8 1966 , that (I) (we) last saw the deceased alive on 10-8 1966 and that death occurred at 10-8 1966 , M, from causes and on the date stated above.			
22a. SIGNATURE <i>Bernardo Alvarado, M.D.</i>		22b. DATE SIGNED 10-13-66	
22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M.D.		22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10-29-66	
23c. NAME OF CEMETERY OR CREMATORIAL Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly Maryland	
24. FUNERAL DIRECTOR Henry W. Penn, Jr., Administrator, Cheverly, Md.		25a. ADDRESS	
25b. REC'D BY REGISTRAR NOV 1 1966		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14633

CERTIFICATE OF DEATH

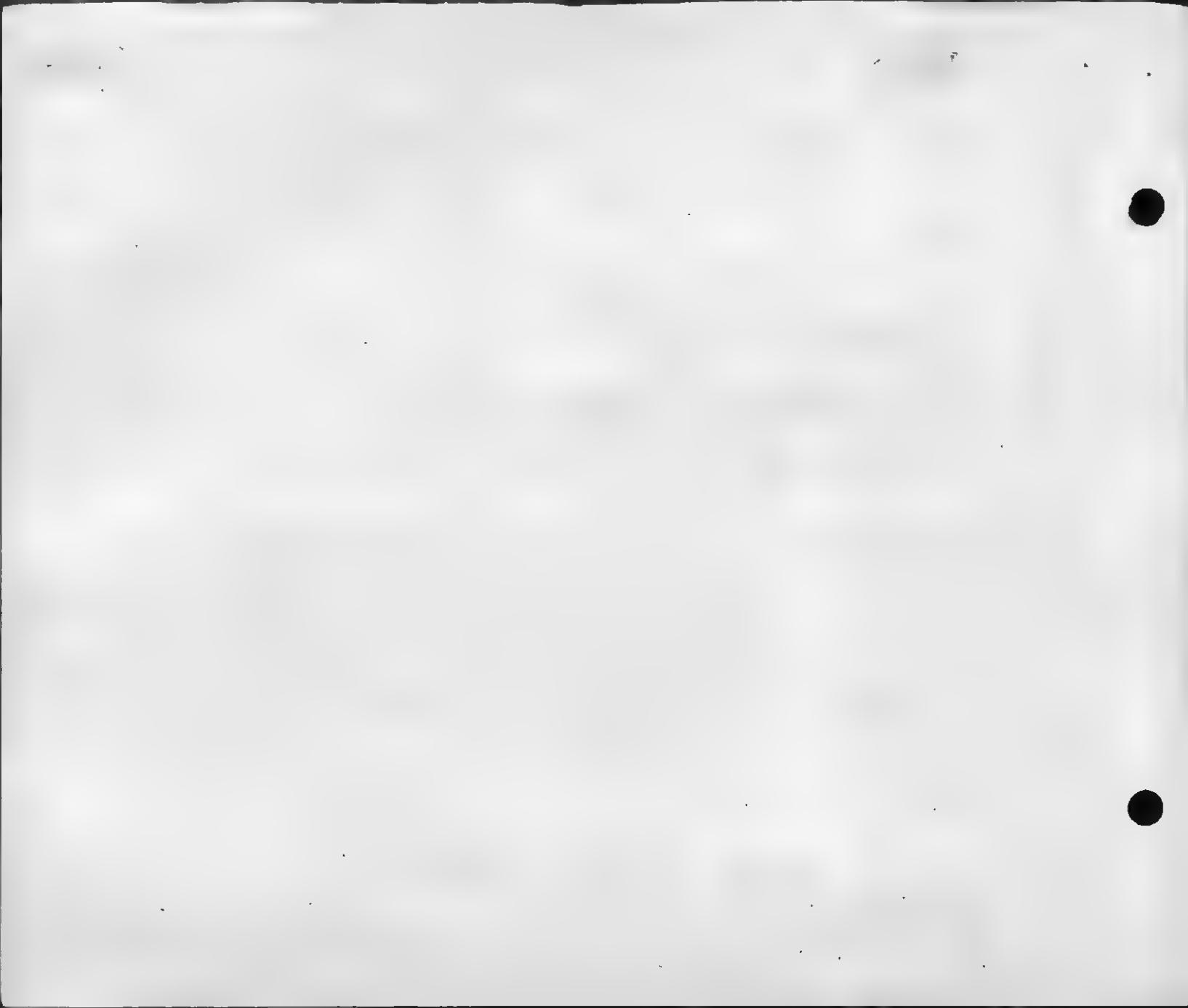
14634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from use as the burial-transit permit. Then break or remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. /

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
Prince Georges		c. LENGTH OF STAY IN 1b		b. STATE MARYLAND b. COUNTY P.G.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
FCRESVILLE		d. STREET ADDRESS		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		d. STREET ADDRESS	
FORRESTVILLE NURSING HOME		d. STREET ADDRESS		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month
Loretta		Kentville Ridgely		10	9
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR
F		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	60 yrs.	Months Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
CLERK		COURT		P.G., MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN FRANCIS RIDGELY		ESTELLA E. SELTZER		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		218-38-8737		CATHERINE RIDGELY, MARLBORO, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. } (b) _____		Myocardial infarction			
DUE TO cause last. } (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
Renal insufficiency. Pyelitis.					
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour _____ p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1966 to 10/9/66, that (I) (was) last saw the deceased alive on 10/9/66, and that death occurred at 8:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>J. Clark H. Jones</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/9/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS FORESTVILLE, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	23d. LOCATION (City, town or county) (State)
BURIAL	10-12-66	MT CARMEL	Upper MARLBORO, MD.
24 FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
HUNT FUNERAL HOME, WALDORF, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	
20M 5-63		DATE OCT 14 1966	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

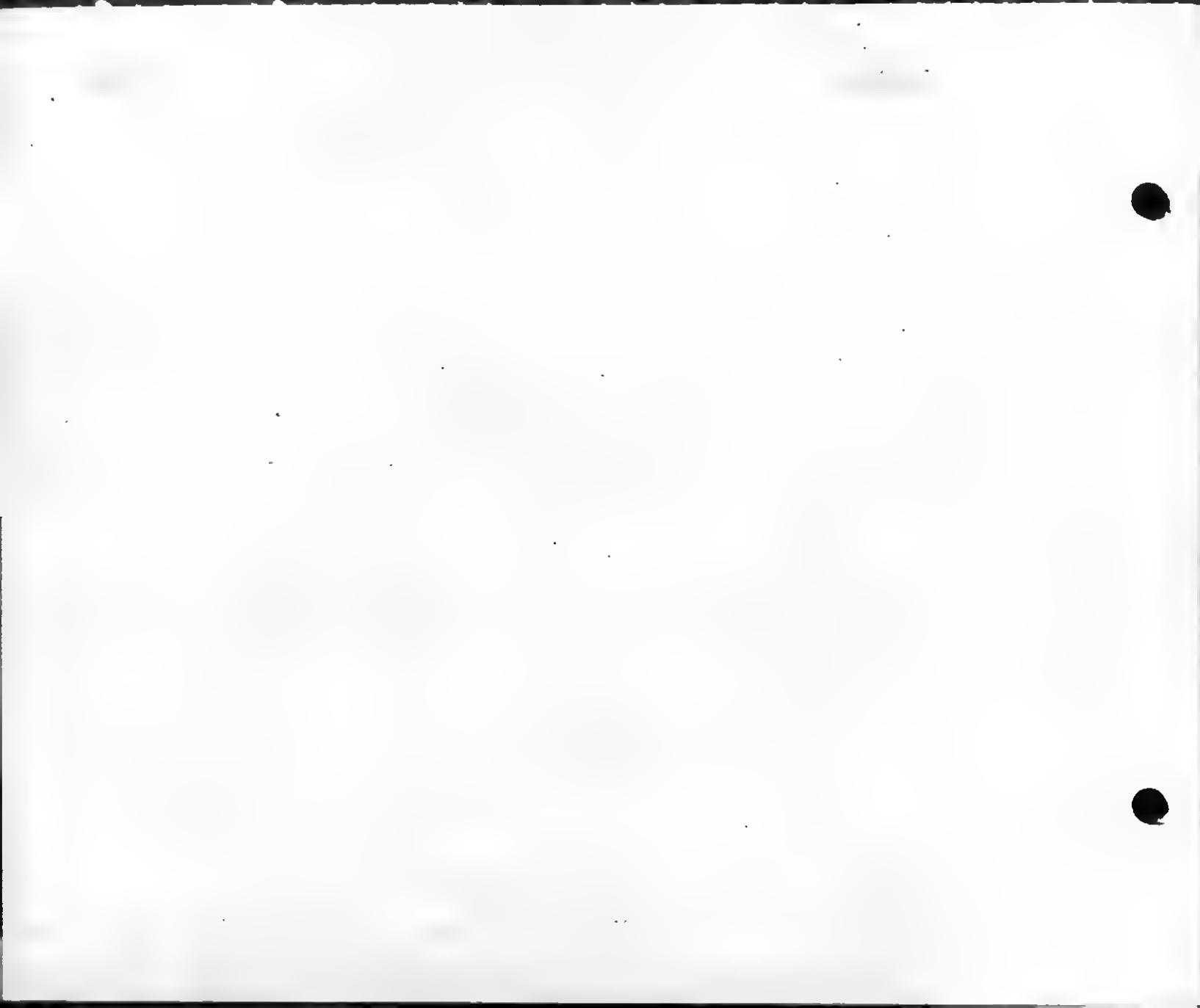
CERTIFICATE OF DEATH

14635

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>MARYLAND</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover, Md.</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Magnolia Nursing Home</i>		d. STREET ADDRESS <i>4712 67th Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Carrie</i>	Middle <i>Louelle</i>	Last <i>Rust</i>
4. DATE OF DEATH	Month <i>Oct.</i>	Day <i>6</i>	Year <i>1966</i>
5. SEX	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH <i>12/10/1879</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Shellman Cooper</i>		14. MOTHER'S MAIDEN NAME <i>SUSAN Catherine Cooper</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Helen Temple Same as #2 Daughter</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cancer of pancreas</i> <i>3 months</i> stating the underlying cause (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-6-66</i> , to <i>10-6-66</i> , 1966, that (I) (we) last saw the deceased alive on <i>10/6 1966</i> , and that death occurred at <i>6:00 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>John J. Kelly Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BUR. A., CREMATION, BURIAL		23b. DATE THEREOF <i>10/8/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify)		23d. LOCATION (City or Town) (County) (State) <i>Taylors Town Loudon Va.</i>	
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>OCT 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

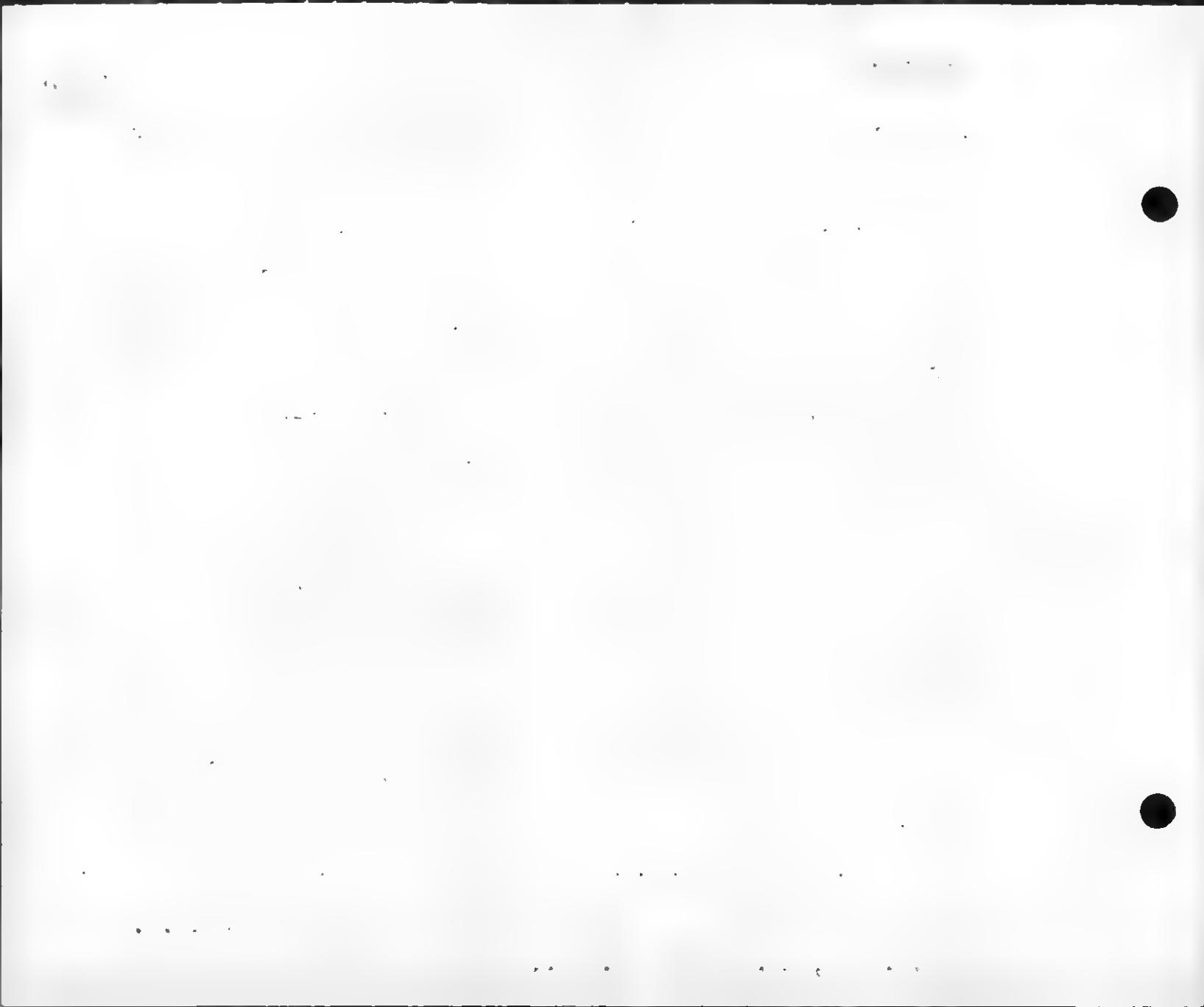
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14635

CERTIFICATE OF DEATH

14636

1 PLACE OF DEATH a. COUNTY Prince George's			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 1520 59th Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print)		First Kimon	Middle M	Last Santos	4. DATE OF DEATH October 19 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Feb. 22, 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		9. AGE (In years last birthday) 70 yrs	
13. FATHER'S NAME Kimon Santos		11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Right coronary artery occlusion with myocardial infarction Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (s) (this hospital) attended the deceased from October 16, 1966, to October 19, 1966, that (s) (we) last saw the deceased alive on October 19, 1966, and that death occurred at 1:15 P.M. from causes and on the date stated above.					
22a. SIGNATURE A. Clark Holmes, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/20/66	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS 4108 Pratt St. Upper Marlboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/66	23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery	23d. LOCATION (City or Town) Washington, D.C.	(County) (State)
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE DC	25a. REC'D BY REGISTRAR OCT 24 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge	DATE



FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											14637			
1. PLACE OF DEATH a. COUNTY <i>Maryland</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i> c. LENGTH OF STAY IN 1b <i>2 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince George's Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>5425 Suitland</i> d. STREET ADDRESS <i>Suitland Md.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>John</i>	Middle <i>Franklin</i>	Last <i>Schaefer</i>	4. DATE OF DEATH <i>Oct. 3</i>	Month <i>Oct.</i>	Day <i>3</i>	Year <i>1966</i>						
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 16, 1931</i>	9. AGE (In years, last birthday) <i>30</i>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/>	Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fix installations</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>McGraw</i>				11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John Wilhelm Schaefer</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Schaefer</i>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>220 34-3241</i>				17. INFORMANT <i>John Schaefer</i>				Address <i>1620 Suitland Rd. Suitland Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cigarette Face - Burns it (Under the eye)</i>														
1. <i>116X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) <i>(Gun shot wound)</i> DUE TO (c) <i>right</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Gun shot wound eye</i>										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>Sept. 1 1966</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Suitland Md.</i>				20f. (City or town) <i>Suitland</i> (County) <i>Prince George's</i> (State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <i>John Schaefer</i>		
												M.D. ASSISTANT MEDICAL EXAMINER <i>John Schaefer</i>		
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
												Address (Street, city, town, or county) <i>1620 Suitland Rd. Suitland Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10/6/66</i>				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Cemetery</i>				23d. LOCATION (City, town or county) <i>Prince Georges, Md.</i> (State)		
24. FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i>								25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE		
								DATE <i>OCT 3 1966</i>						





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14638

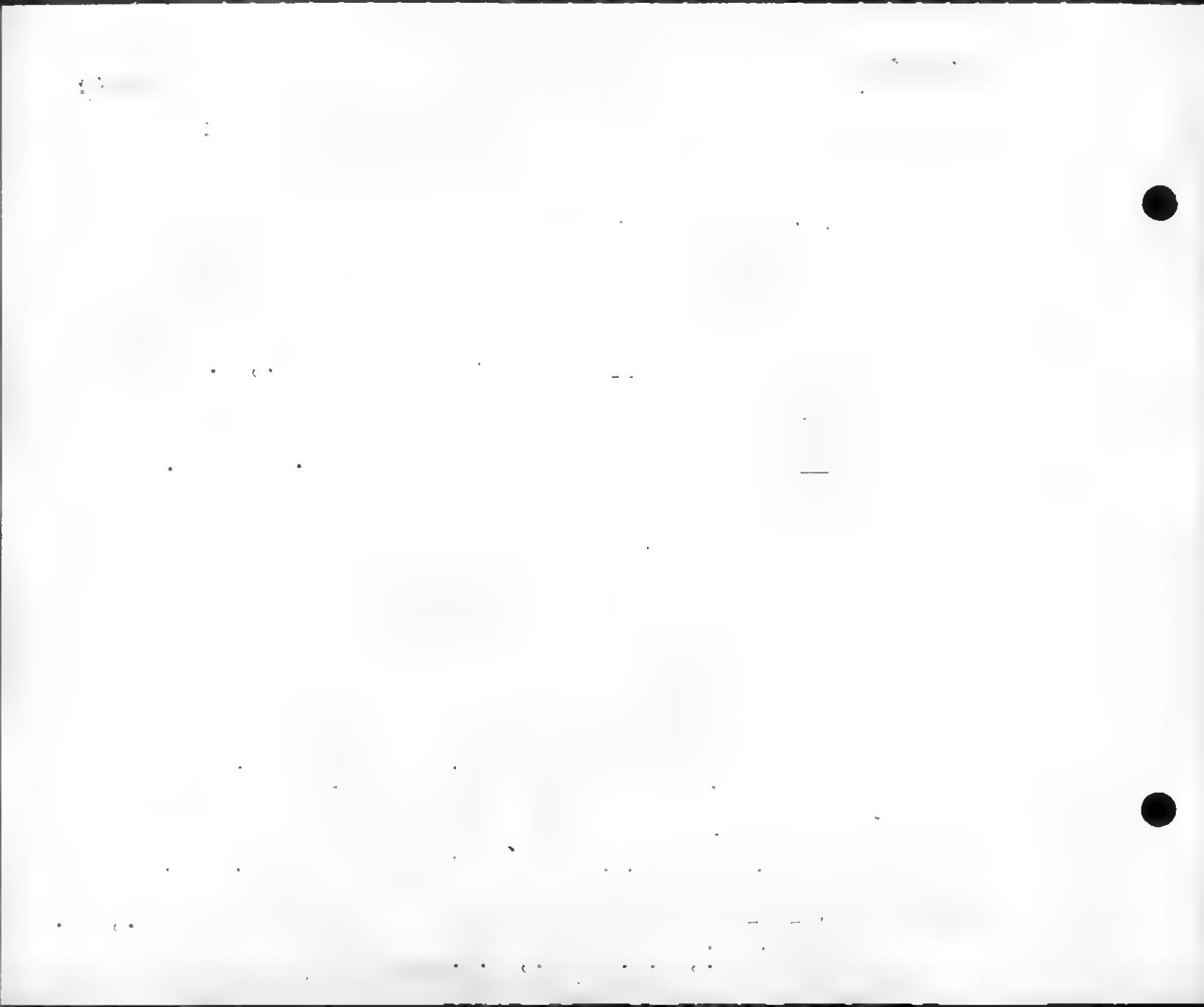
CERTIFICATE OF DEATH

14639

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince Georg'es		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS --	
3. NAME OF DECEASED (Type or print) First Pauline Middle B Last Sellman		4. DATE OF DEATH Month October Day 14 Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Prince George Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilson Sellman		14. MOTHER'S MAREN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Address Ethel Abrahms Bx. 2085 Upper Marlboro Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO (c) stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH Pneumonia Carcinoma of pancreas Cushing's disease metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	
(State)			
21. I certify that (s) (this hospital) attended the deceased from Sept. 19, 1966, to Oct. 14, 1966, that (I) (we) last saw the deceased alive on Oct. 14, 1966, and that death occurred at 1:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jose A. Garcia, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED PM 10-14-66
22c. PHYSICIAN'S NAME (Type) Jose A. Garcia, M.D.		22d. ADDRESS Prince George's Genl. Hosp., Cheverly Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-66	23c. NAME OF CEMETERY OR CREMATORIAL Moses Cemetery
24. FUNERAL DIRECTOR Rollins, Inc.		ADDRESS 4339 Hunt Pl., N.E. Wash., D.C.	25a. REC'D BY REGISTRAR DATE OCT 15 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

14639

CERTIFICATE OF DEATH

14640

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4** may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b 1 mo. 15 days		d. STREET ADDRESS 4015 Nicholson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Bernard		First B Middle P	4 DATE OF DEATH SHIELDS October 19 1966
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-21-78
9 AGE (In years lost birthday) 87 yrs		10. IF UNDER 1 YEAR, Months 0 Days 0 Hours 0 Min. 0	
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Quartermaster		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.	
12. CIT ZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Samuel E. Shields		14. MOTHER'S MAIDEN NAME Josephine Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220 44 5817	
17. INFORMANT Bernard F. Shields same as #2 (son)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>multiple pulmonary Emboli w/ dyspnea</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Cerebral dyspnea</i>			
DUE TO (c) <i>Generalized Cerebrovascular</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that 1 (this hospital) attended the deceased from Aug. 2, 1965 to 10-19, 1966 , that 1 (we) lost saw the deceased alive on 10-19, 1966 , and that death occurred at 1:45 PM , from causes and on the date stated above.		22b. DATE SIGNED 10-19-66	
22a. SIGNATURE R.D.Bauer M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 2515 Buck Lodge Rd. Adelphi, Md.
22c. PHYSICIAN'S NAME (Type) R.D.Bauer, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/22/66	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet
23d. LOCATION (City or Town) Washington D. C.		(County) (State)	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE OCT 24 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14641

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. LENGTH OF STAY IN lb Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Naval Air Facility Barracks	
3. NAME OF DECEASED (Type or print) Billy Edward Simpson		4. DATE OF DEATH 10 23 19 66	Month Day Year
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED Never married	8. DATE OF BIRTH 28 July 1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
13. FATHER'S NAME Billy H. Simpson		14. MOTHER'S MAIDEN NAME Alice Horan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO Active Duty Unknown	17. INFORMANT Alice Albritton
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8234 Hemothorax, left chest		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Laceration of left lung		DUE TO	
		(b) From fracture of sternum	
		DUE TO	
		and multiple fractures of skull	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which ran off road and hit gaurd rail.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:25am 10-23-1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 495 south of Balt. Wash. Parkway.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-24-66	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memory Gardens Okla. City, Oklahoma
24. FUNERAL DIRECTOR W.W. Chambers Co., Inc. 1400 Chapin St. N.W.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE
			DATE OCT 31 1966

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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14641 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14643

1. PLACE OF DEATH B. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
Prince George's MARYLAND		Maryland Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cheverly		DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Deanwood Park	
Prince George General Hospital		1411 Eastern Avenue	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Cecil	Last Smith
4. DATE OF DEATH	Month 10	Day 8	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-20-1919
9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? USA
Laborer		Virginia	
13. FATHER'S NAME			
Wade Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
		Address Rosalee Smith-1411 Eastern Avenue	

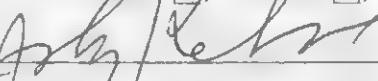
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma		
1-7 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of pancreas		over 2 mo.
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
---	--	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

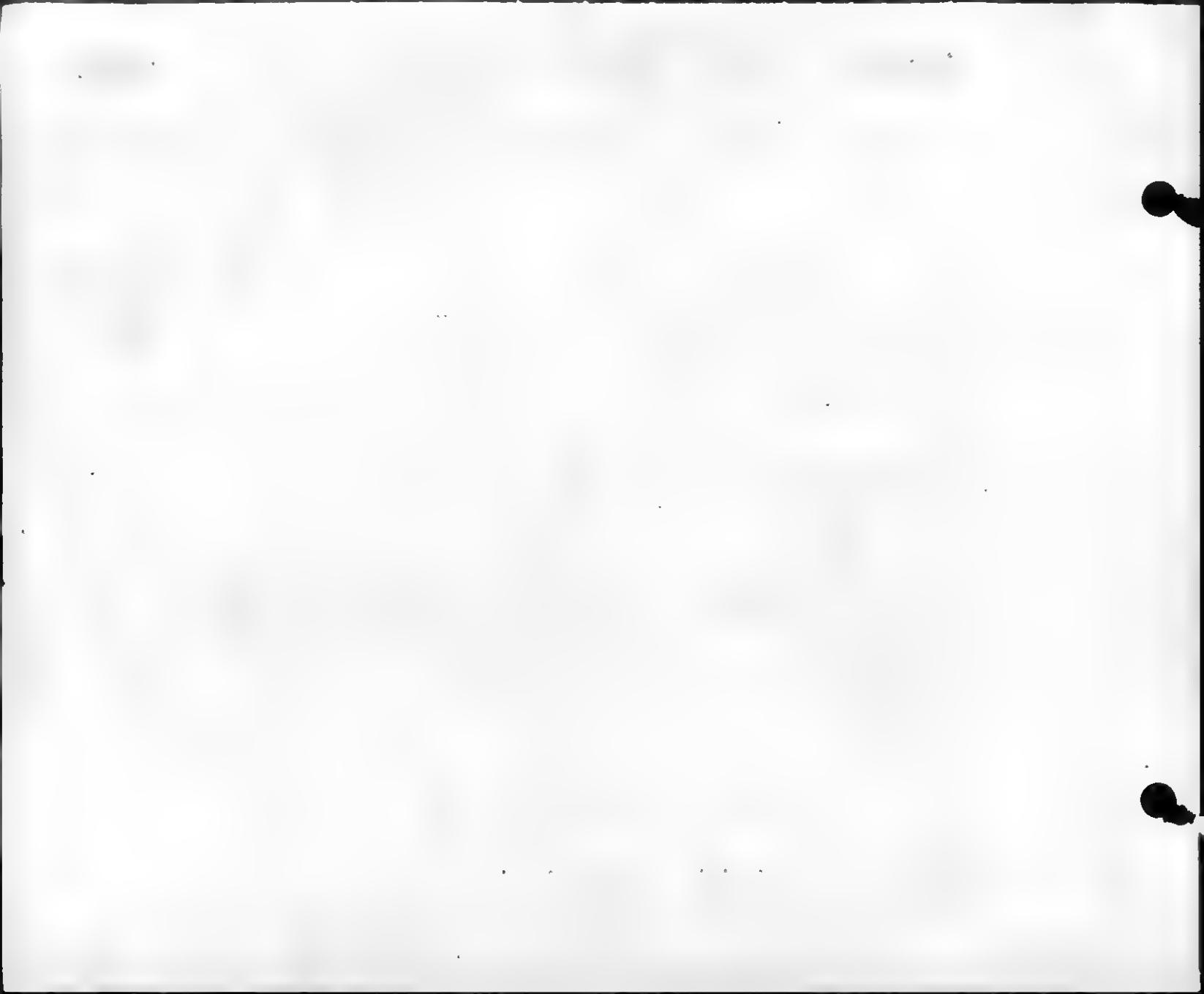
21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE 
CHIEF MEDICAL EXAMINER
M.D. ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER

EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. Address (Street, city, town, or county) 10-10-66

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/15/66	23c. NAME OF CEMETERY OR CREMATORIALY Harmony Memorial Park	23d. LOCATION (City, town or county) Maryland (State)
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24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Road, N.E.	ADDRESS John T. Stewart	25a. REC'D BY REGISTRAR DATE OCT 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14642

CERTIFICATE OF DEATH

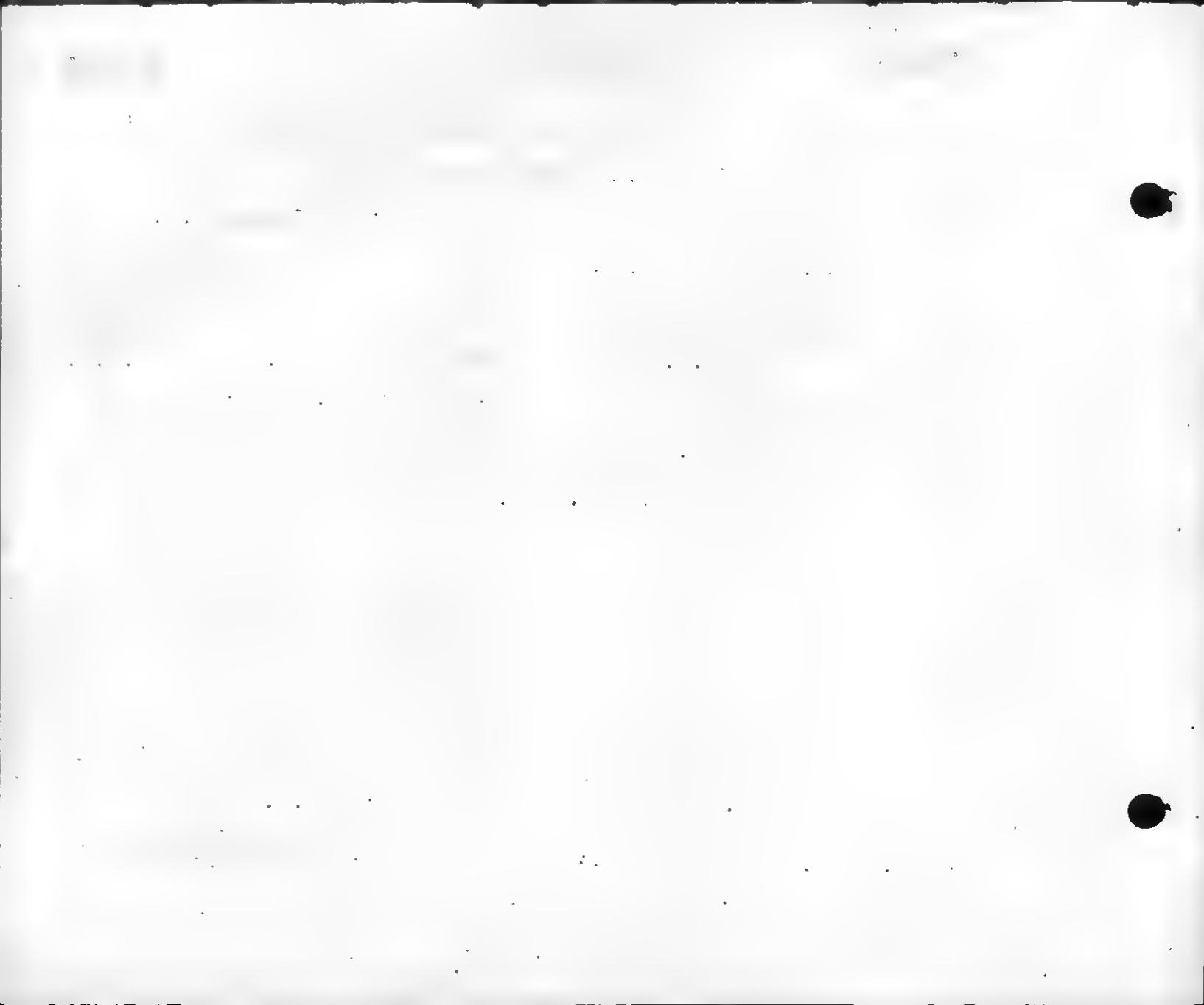
14644

Item #102 11-1302 10/25/66

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit document. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		b. COUNTY PRINCE GEORGE'S	
c. LENGTH OF STAY IN 1b 186 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5316 HENDERSON ROAD S.E.	
3. NAME OF DECEASED (Type or print) LAWRENCE RAYMOND		4. DATE OF DEATH Month Day Year OCTOBER 21 1966	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8 MAY 1913	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10b. KIND OF BUSINESS OR INDUSTRY aviation machi	
13. FATHER'S NAME JACOB MELVIN SMITH		11. BIRTHPLACE (County & State, or foreign country) HUGHESVILLE, PA.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1931-1959		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 579-46-0315		17. INFORMANT Address GRACE E SMITH-WIFE-SAME AS #2 ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULAR CELL SARCOMA			
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) USAF HOSPITAL ANDREWS, ANDREWS AFB, WASHINGTON DC 20331	
21. I certify that (this hospital) attended the deceased from 18 APR 1966 to 21 OCT 1966 , that (we) last saw the deceased alive on 21 OCT 1966 and that death occurred at 9:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Frederick L. Sachs</i>			
22b. DATE SIGNED 21 OCT 66			
22c. PHYSICIAN'S NAME (Type) FREDERICK L. SACHS, CAPT, USAF, MC		22d. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> USAF HOSPITAL ANDREWS, ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/25/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. Suitland Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1
FOR STATE
HEALTH DEPT.

14643

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14645

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills 16	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 6430 Gull Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Leonard	Middle Vincent	Last Smith, Jr.
4. DATE OF DEATH 10 17 19 66	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 14 May 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor Group		9. AGE (In years last birthday) IF UNDER 1 YEAR 18 yrs. IF UNDER 24 HRS. Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Leonard V. Smith, Sr.		14. MOTHER'S MAIDEN NAME Rosalie K. Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Leonard V. Smith, Sr. Same as Item #2 Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
77 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		Barbiturate intoxication (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Ingested overdose of barbiturates	
20c. TIME OF INJURY Month, Day, Year Hour a.m. AM 19-17 19 66 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
		20f. (City or town) Temple Hills	(County) Pr. Geo. Md. (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> OEPDEUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22. DATE SIGNED 10-17-66
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 20, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington Nat'l. Cemetery
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR DATE OCT 19 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14644

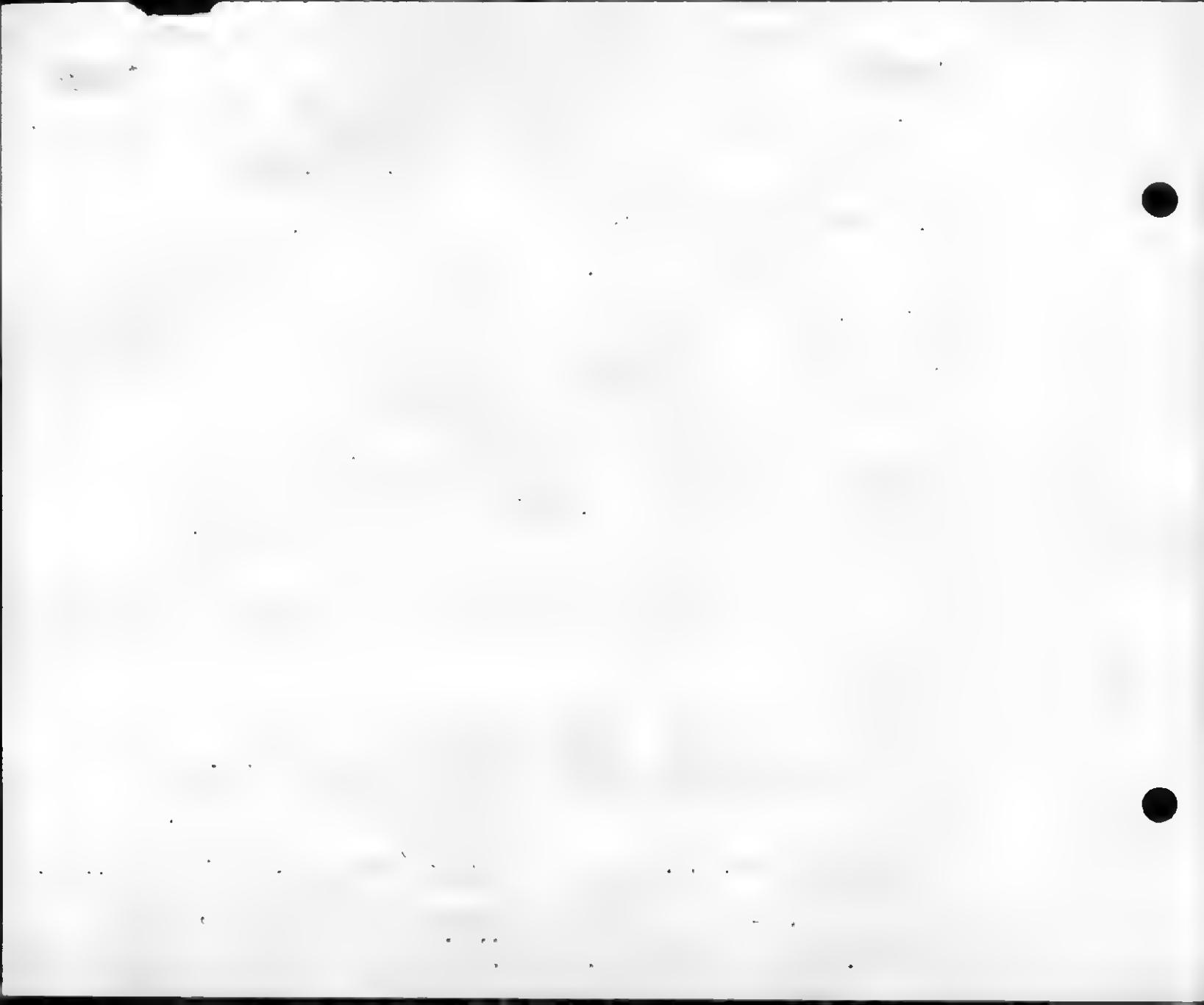
Item #7 File #137133
Items #7, 8 & 9 File #133166 pc

14646

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb 7 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		d. STREET ADDRESS 6119 C St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle C.	Last Smith
4. DATE OF DEATH October 1 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED / NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/74/1892
9. AGE (In years last birthday) 74/73 yrs	10. UNDER 1 YEAR Months 74/73 yrs	11. UNDER 24 HRS Hours 74/73 yrs	
10a US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Austria - Hungary		12. CIT ZEN OF WHAT COUNTRY? No	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute peritonitis with Rt subdiaphragmatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Probable carcinoma of gall Bladder with extension DUE TO (c) to the liver & peritoneal cavity.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Bladensburg		(County) Maryland	
(State) MD		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MEDICAL CERTIFICATION			
21. I certify that (I) (this hospital) attended the deceased from 9/24/66 , 19 1966 , to Oct. 1, 1966 , that (I) (we) last saw the deceased alive on October 1 1966 , and that death occurred at 2:15 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter Duus</i>		PM M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 10-1-66
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 5-1966	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery
23d. LOCATION (City or Town) Bladensburg		(County) Maryland	
(State) MD		25a. RECD BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i> Simmons Bros. Funeral Home 1661-Gd. Hope Rd. SE		ADDRESS Wash., DC.	25b. REGISTRAR'S SIGNATURE OCT 5 1966
25c. REC'D BY REGISTRAR Charles Judge		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14645

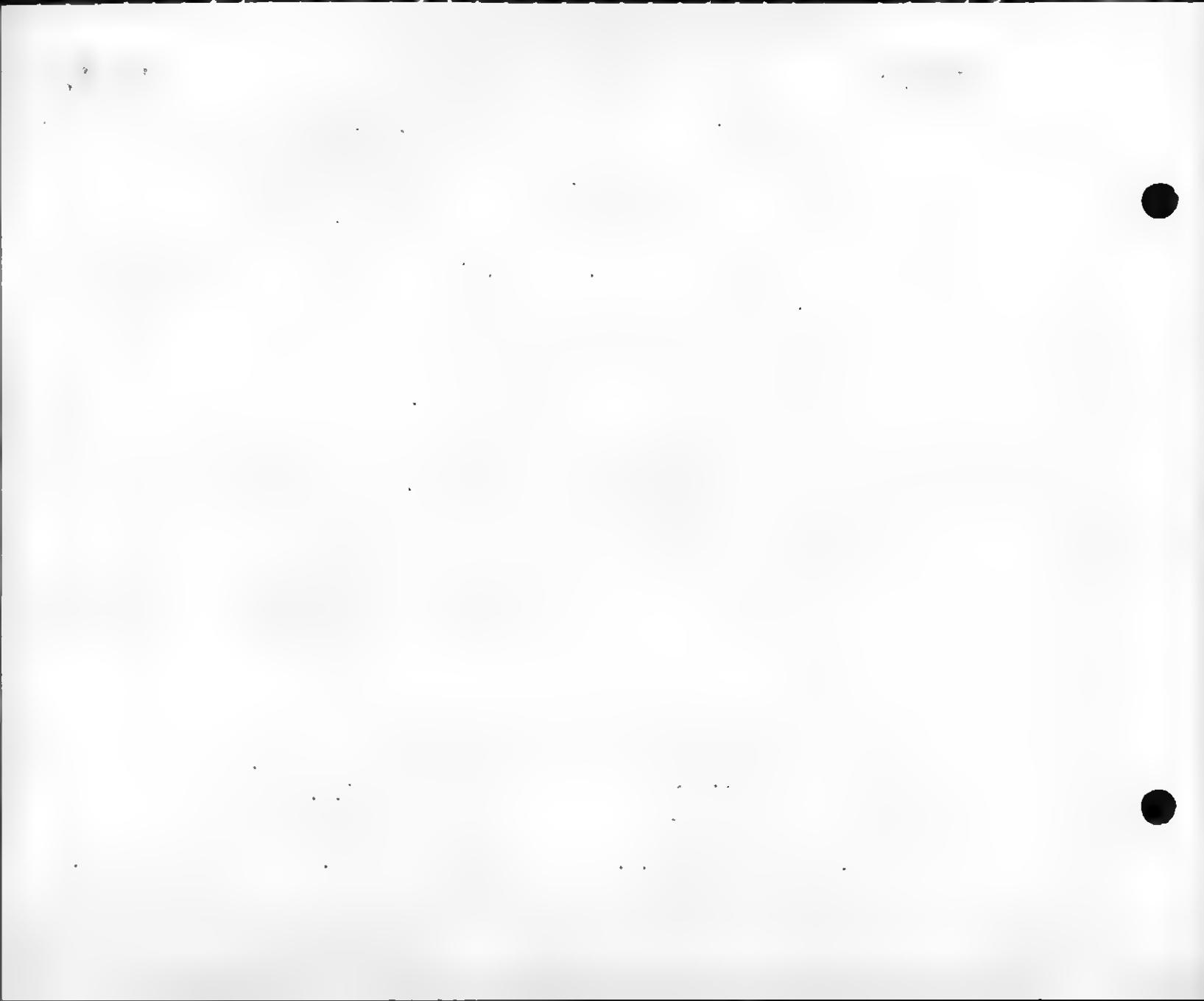
CERTIFICATE OF DEATH

14647

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		E. Riverdale 16.1	
3. NAME OF DECEASED (Type or print) First Grace Middle M. Last Snider		4. DATE OF DEATH Month October 8, 1966 Day Year 1966	
5. SEX Female White		6. COLOR OR RACE 7. MARRIED WIDOWED NEVER MARRIED DIVORCED	
10e USUAL OCCUPATION (Give kind of work done during most of work life even if retired) Housewife		10b. KIND OF BUSINESS OR IND. STRY own home	
11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		9. AGE (In years) 60 last birthday yrs	
12. CITIZEN OF WHAT COUNTRY U.S.		10. UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME Clarence Cheek		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 17. INFORMANT Joyce McCoy 209 South Main St Moorefield, West Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Rheumatic heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 29, 1966, to Oct. 8, 1966, that (I) (we) last saw the deceased alive on Oct. 8, 1966, and that death occurred at 2:10 P.M., from causes and on the date stated above.			
22a. SIGNATURE A. Clark Holmes, M.D.		22b. DATE SIGNED 10/8/66	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS 4108 Pratt St., Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-66	
23c. NAME OF CEMETERY OR CREMATORIAL WASHINGTON NATIONAL		23d. LOCATION (City or Town) Burtonsville, Md.	
24. FUNERAL DIRECTOR ADDRESS W.W. Chambers Co. Riverdale Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

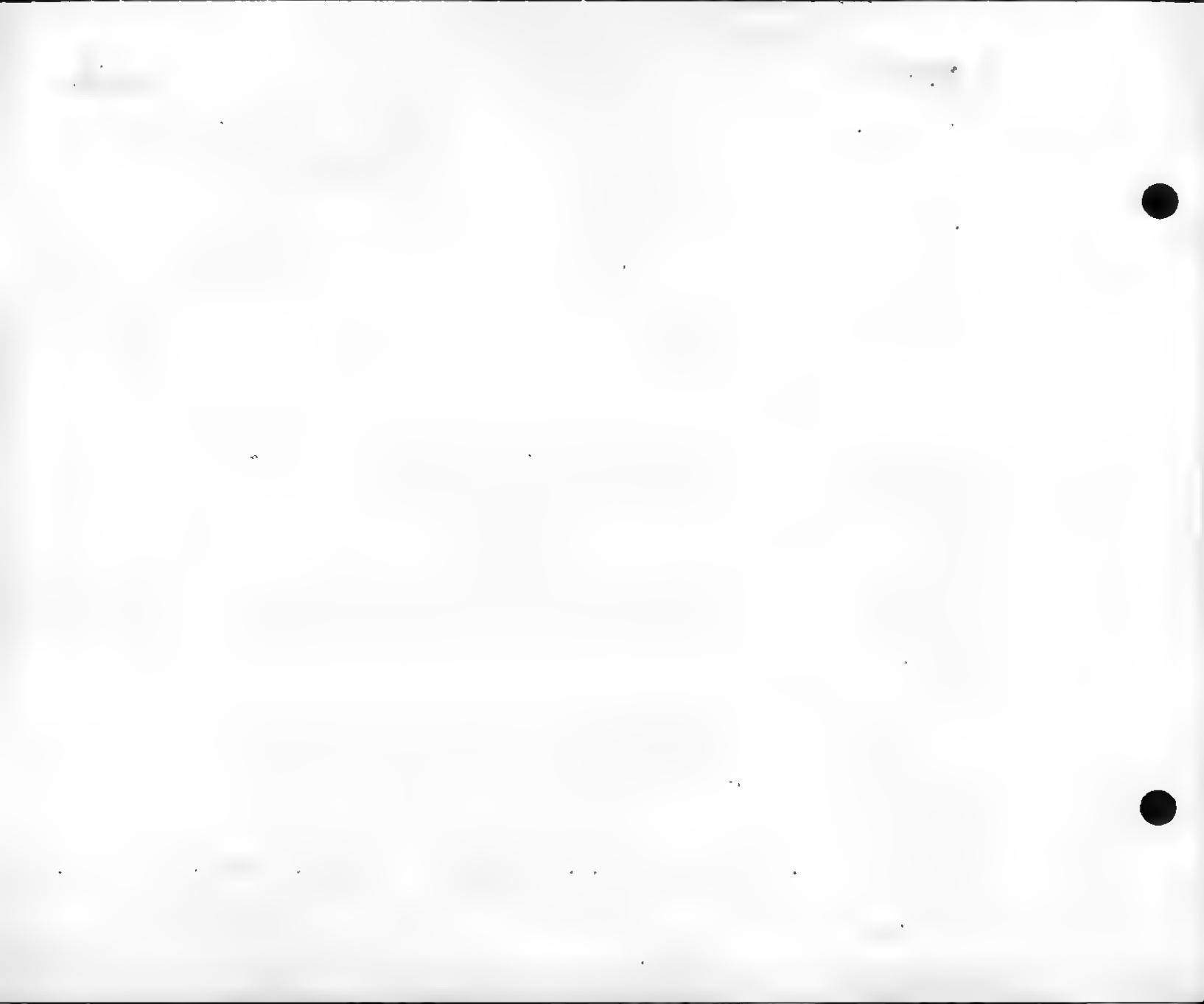


MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						14648							
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights										
c. LENGTH OF STAY IN lb 2 days			d. STREET ADDRESS 5749 Southern Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital													
3. NAME OF DECEASED (Type or print) Alex V Sorenson		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX	6. COLOR OR RACE	7. MARRIED	<input type="checkbox"/> NEVER MARRIED	<input checked="" type="checkbox"/> X	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS					
Male	White	WIDOWED	<input type="checkbox"/>	<input type="checkbox"/> DIVORCED	March 21, 1905	61 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER (RETIRED)			10b. KIND OF BUSINESS OR INDUSTRY UNK.			11. BIRTHPLACE (County & State, or foreign country) UNK.							
13. FATHER'S NAME UNK.						14. MOTHER'S MAIDEN NAME UNK.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address Mrs. L. Thompson 510 61st Ave CAPITA Heights MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peritonitis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UNK												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) UNK											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
p.m. 19													
21. I certify that 19 (this hospital) attended the deceased from October 11, 1966 , to October 13, 1966 that 11 (we) last saw the deceased alive on October 13, 1966 , and that death occurred at 6:30PM, from causes and on the date stated above.													
22a. SIGNATURE A. Clark Holmes		M.D. ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/14/66							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4108 Pratt St. Upper Marlboro, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF Oct. 17, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS LEE FUNERAL HOME		23d. LOCATION (City or Town) WASHINGTON D.C.		(County)		(State)			
24. FUNERAL DIRECTOR LEE FUNERAL HOME						25a. REC'D BY REGISTRAR OCT 18 1966				25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20 M 1/66													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

FOR STATE
HEALTH DEPT

14647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14649

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day
Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

INTERVAL BETWEEN
ONSET AND DEATH445X
Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Hyperfibrinolysis Cardiac 26 weeks

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

3501-14th

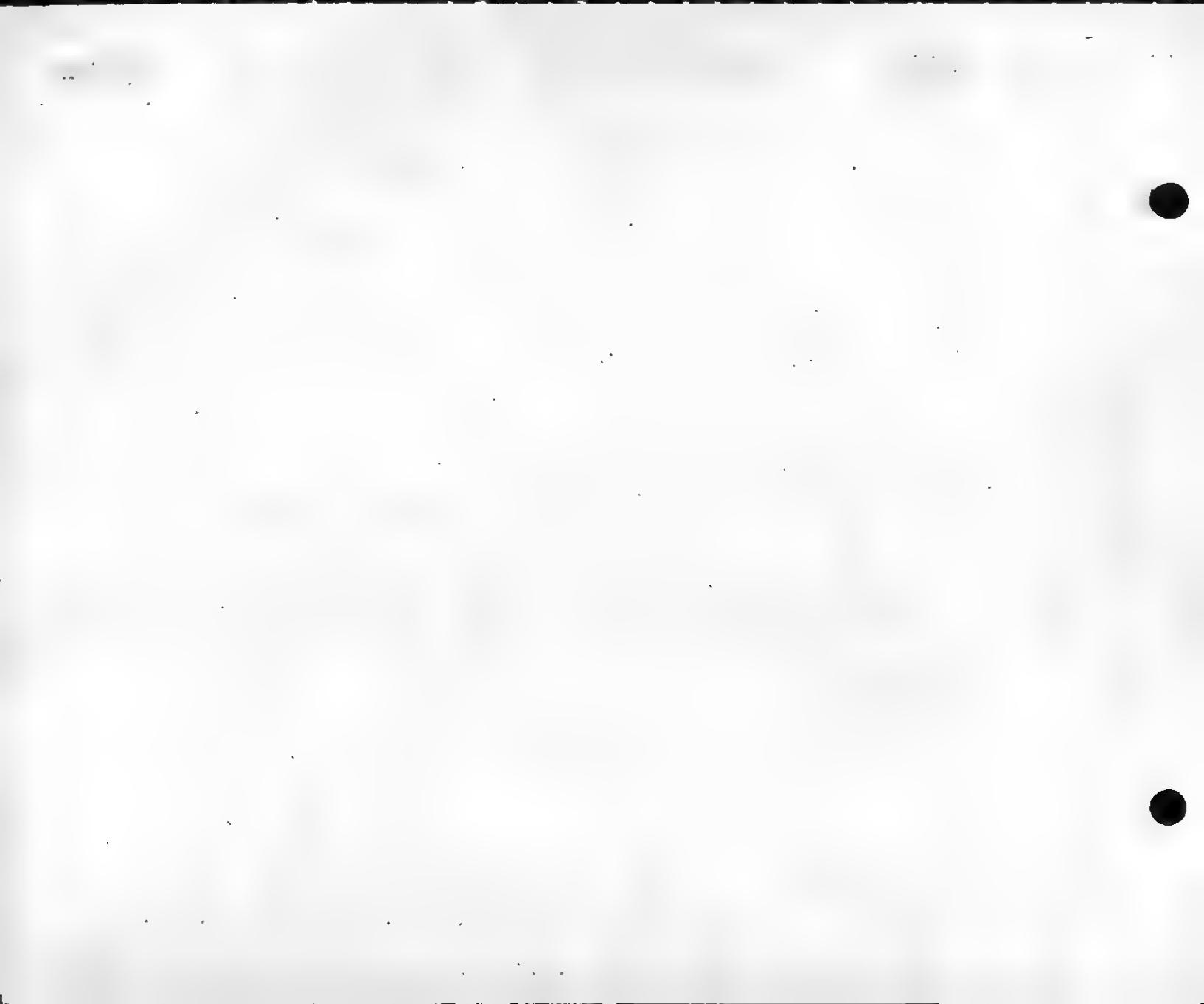
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Bernard Danzansky & Sons St., N.W. Wash. D.C. DATE OCT 3 1966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14650

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Maryland		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Prince George's	
7 Annes		C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
1 day		C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
1 day		3 Annes Place	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		f. IS RESIDENCE ON A FARM?	
3 Annes Place		YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
M		W	W
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
1911-12-24		84 yrs.	11. BIRTHPLACE (State or foreign country)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
Businessman - office executive		Businessman	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank Stevens		Velma Horton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		54-476-60	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Gastritis (due to alcohol & smoking)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		OUT TO (b)	Alcohol (due to alcohol & smoking)
		OUT TO (c)	Smoking (due to alcohol & smoking)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?	
Subject to multiple sclerosis for many years		Yes <input type="checkbox"/> ND <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3 - p.m. 10 - 11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
			Samuel's Home
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM
Burial		10/5/66	Arlington National
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR
		Laurel, Md.	25b. REGISTRAR'S SIGNATURE
			DATE OCT. 10 1966
			Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. The Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'Pending', in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14651

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA			b. COUNTY Prince George's		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) Prince George General Hospital			d. STREET ADDRESS 5513 Nicholson Street, Apt. 103		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Herman Jacob Svoboda			First	Middle	Last
4. DATE OF DEATH 10 23 1966	Month	Day	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 13 Nov. 1921	9. AGE (in years lost birthday) 44 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled Veteran		11. KIND OF BUSINESS OR INDUSTRY U.S. Government		12. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
13. FATHER'S NAME Joseph Svoboda		14. MOTHER'S MAIDEN NAME Viola Schutz		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO WW 11 578 12 5220		17. INFORMANT Viola Svoboda Same as #2 (mother)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure f d C U Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
DUE TO Arteriosclerotic heart disease over 5 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 10-24-66	
23a. BURIAL, CREMATION, BARRIERS (Specify) Burial	23b. DATE THEREOF 10/27/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Arlington, Va.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REG. STAR DATE OCT 27 1966	25b. REGISTERED SIGNATURE J. Francis Gasch's Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14650

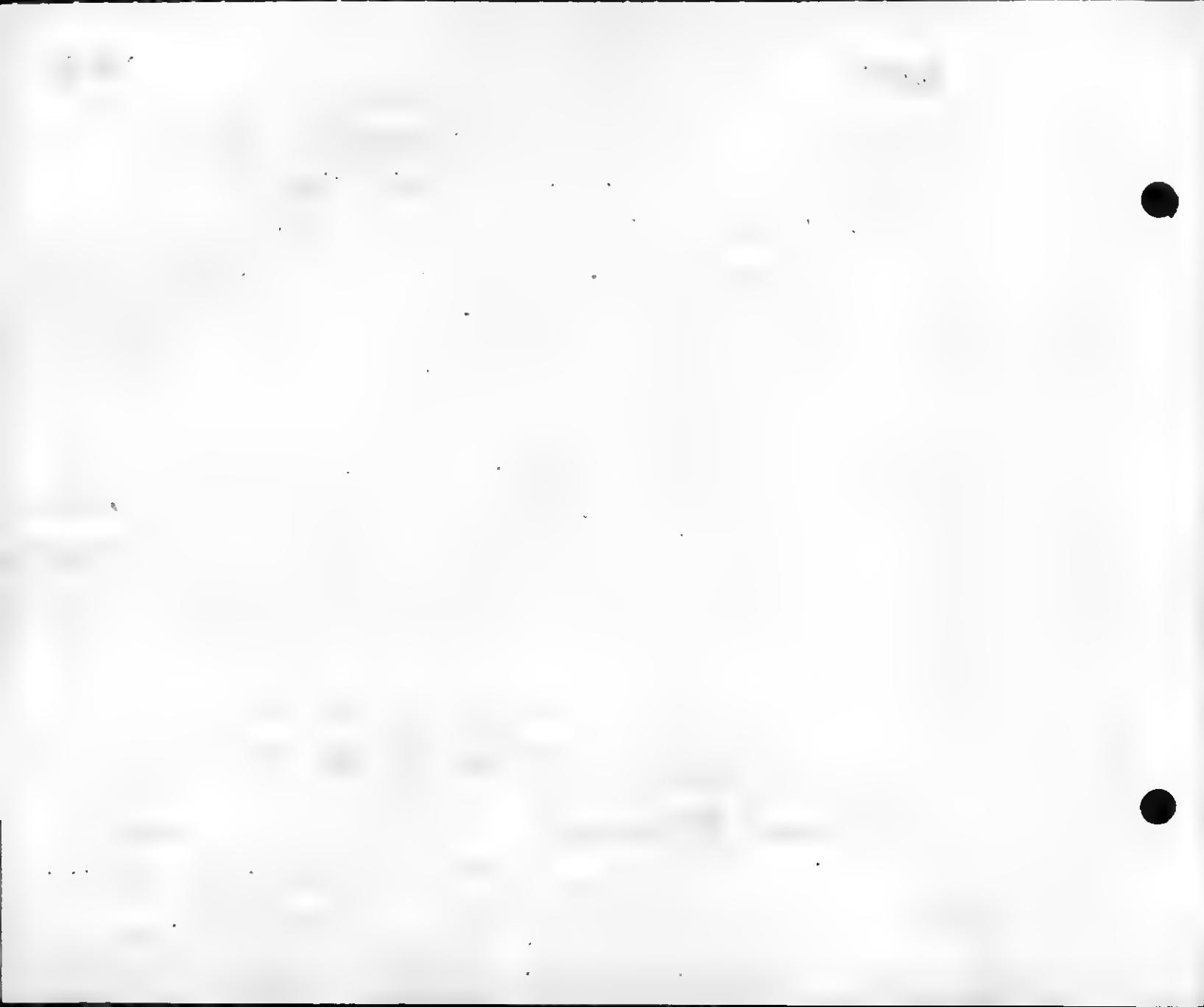
CERTIFICATE OF DEATH

14652

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 mo. 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle A.	Last Taylor
4. DATE OF DEATH October 2 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH July 6, 1917	9. AGE (In years last birthday) 49 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0 Hours 0 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY GPO	
11. BIRTHPLACE (County & State, or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Taylor		14. MOTHER'S MAIDEN NAME Margaret Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Mrs. Mary Lee Taylor 7408 Glendora Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 10 days 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteria Multiple Myeloma (c) 10 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6
20f. (City or town) 6		(County) 6 (State) 6	
21. I certify that (I) (this hospital) attended the deceased from DEC 18 1966 to OCT 2 1966 , that (I) (we) last saw the deceased alive on OCT 1 1966 , and that death occurred at 8:55P M, from causes and on the date stated above.			
22a. SIGNATURE Samuel Dr. Sugar		22b. DATE SIGNED OCT 3 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Samuel Sugar		22d. ADDRESS 4637 Eastern Avenue, Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/66	
23c. NAME OF CEMETERY OR CREMATORIAL Lynnurst Cemetery		23d. LOCATION (City or Town) (County) (State) Knoxville, Tenn.	
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. Suitland, Md.		25a. RECD BY REGISTRAR OCT 5 1966	
		25b. REGISTRAR'S SIGNATURE George	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

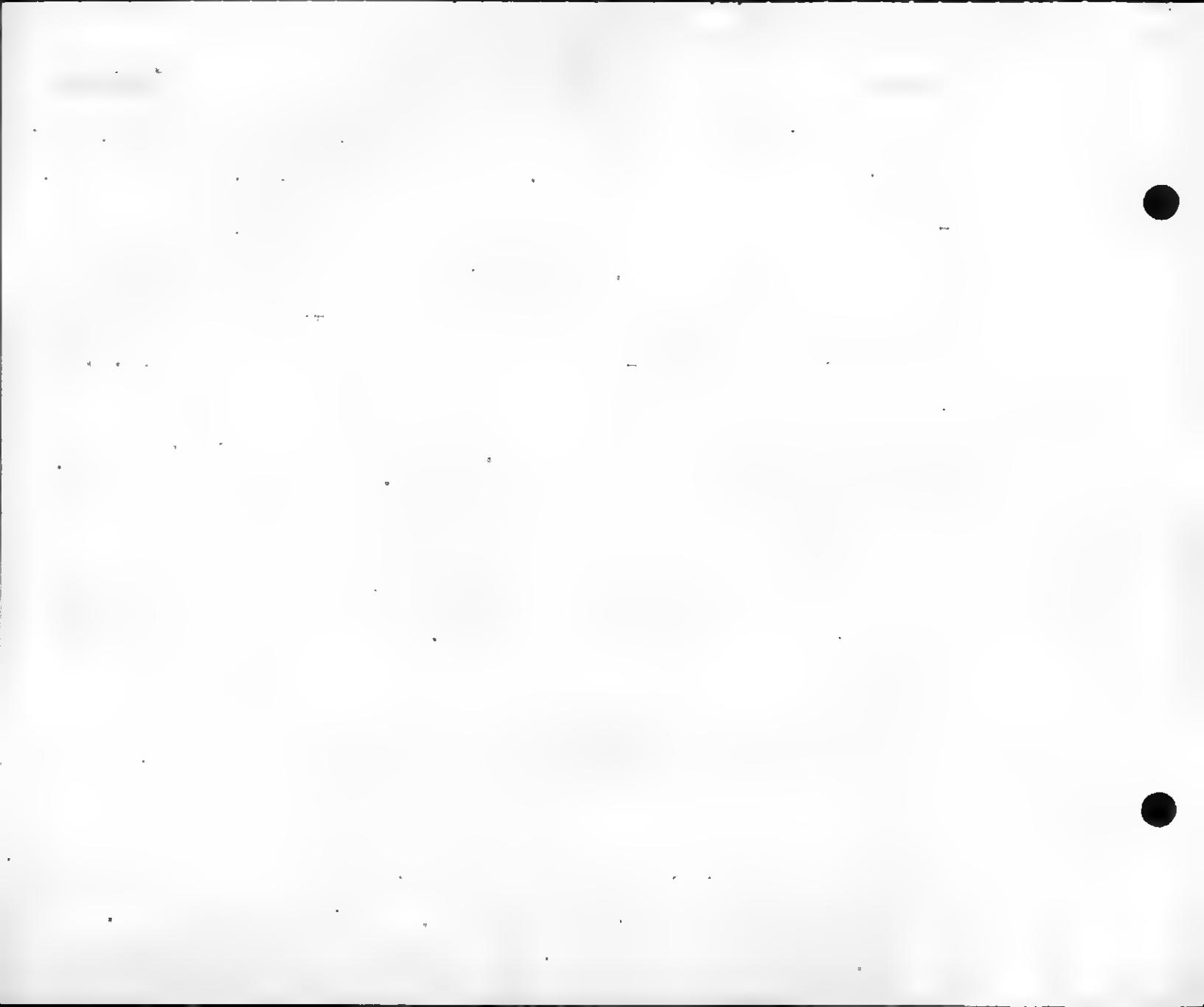
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

14651		14653	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt c. LENGTH OF STAY IN b. 30 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 C Crescent Rd., Greenbelt, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 44-C Crescent Road		d. STREET ADDRESS 44 C Crescent Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle P. Tchikoff		4. DATE OF DEATH October 29, 1966	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/1885 9. AGE (In years last birthday) 80 yrs	
10. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Ukrania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME ? Roussin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Alla T. Ford - 114 - S. Palm Way Lake Worth, Fla.		18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO (b) Coronary sclerosis 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c) General arteriosclerosis 15 years stating the underlying cause (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac pectoral for past 3 months.	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.		22b. DATE SIGNED 10-31-1966	
22a. SIGNATURE Hans Wodak, M. D.		22d. ADDRESS Professional Bldg., Centerway, Greenbelt	
22c. PHYSICIAN'S NAME (Type) Hans Wodak, M. D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 11/3/66	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) Fort Lincoln Cem. Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland	
25a. REC'D BY REGISTRAR NOV 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

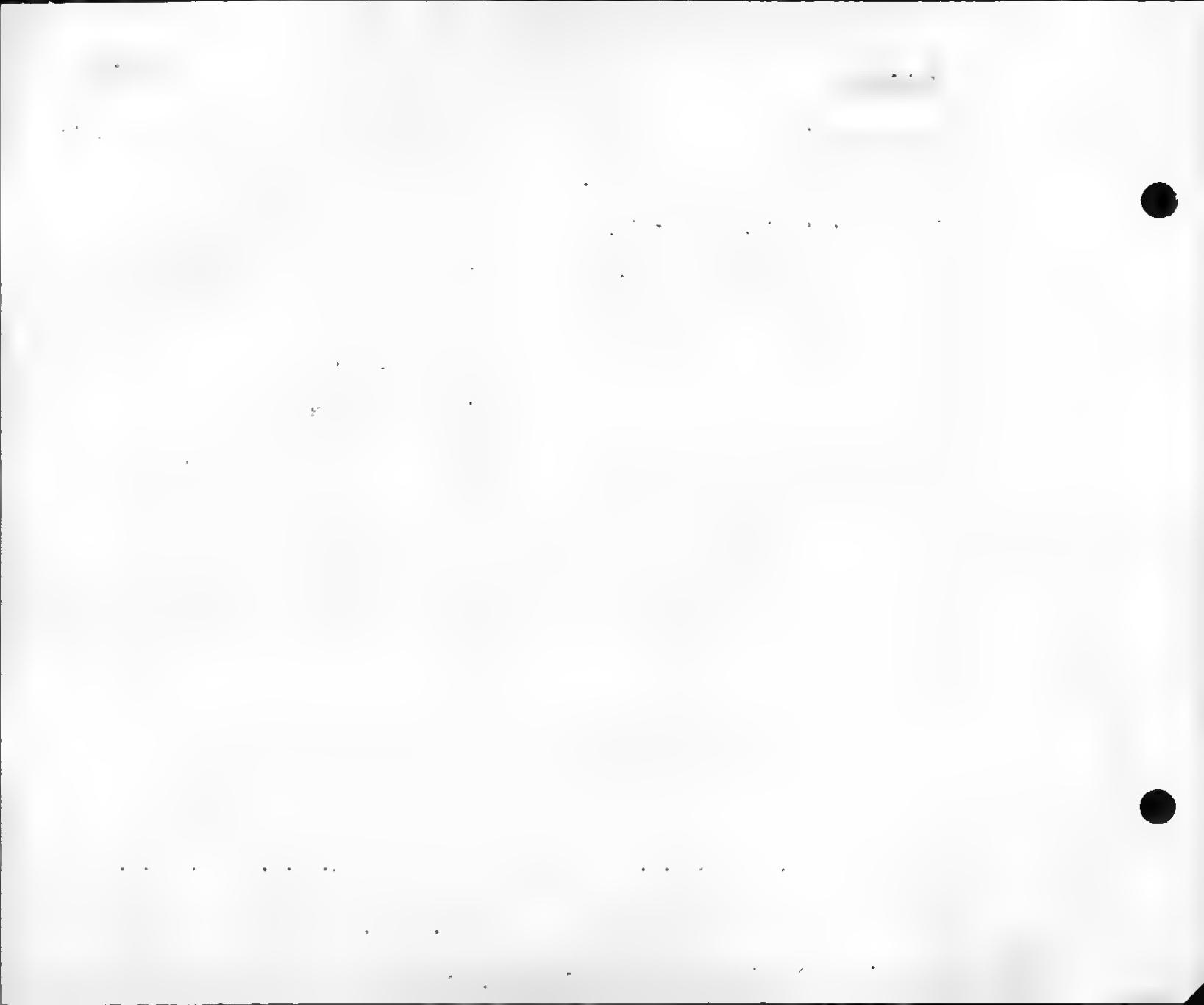
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please, remove, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14654

14652		2 USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admission)	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN lb 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7904 Glenarden Parkway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	4. DATE OF DEATH October 3 1966
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
13. FATHER'S NAME Joe Thomas		9. AGE (in years lost birthday) Yrs 1	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Mother		Address as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7700 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hydrogels Zofalics		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from October 3, 1966 , to October 3, 1966 , that (s) (we) last saw the deceased alive on October 3, 1966 , and that death occurred at 8:05AM , from causes and on the date stated above.			
22a. SIGNATURE Hugh G. Clark		22b. DATE SIGNED Oct 3 1966	
22c. PHYSICIAN'S NAME (Type) Hugh G. Clark, M.D.		22d. ADDRESS 4325 49th St. N.W. Wash., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/8/66	23c. NAME OF CEMETERY OR CREMATORIALy Prince George's Gen Hosp
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Administrator, Cheverly, Md.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
25a. RECEIVED BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
DATE OCT 13 1966			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14653

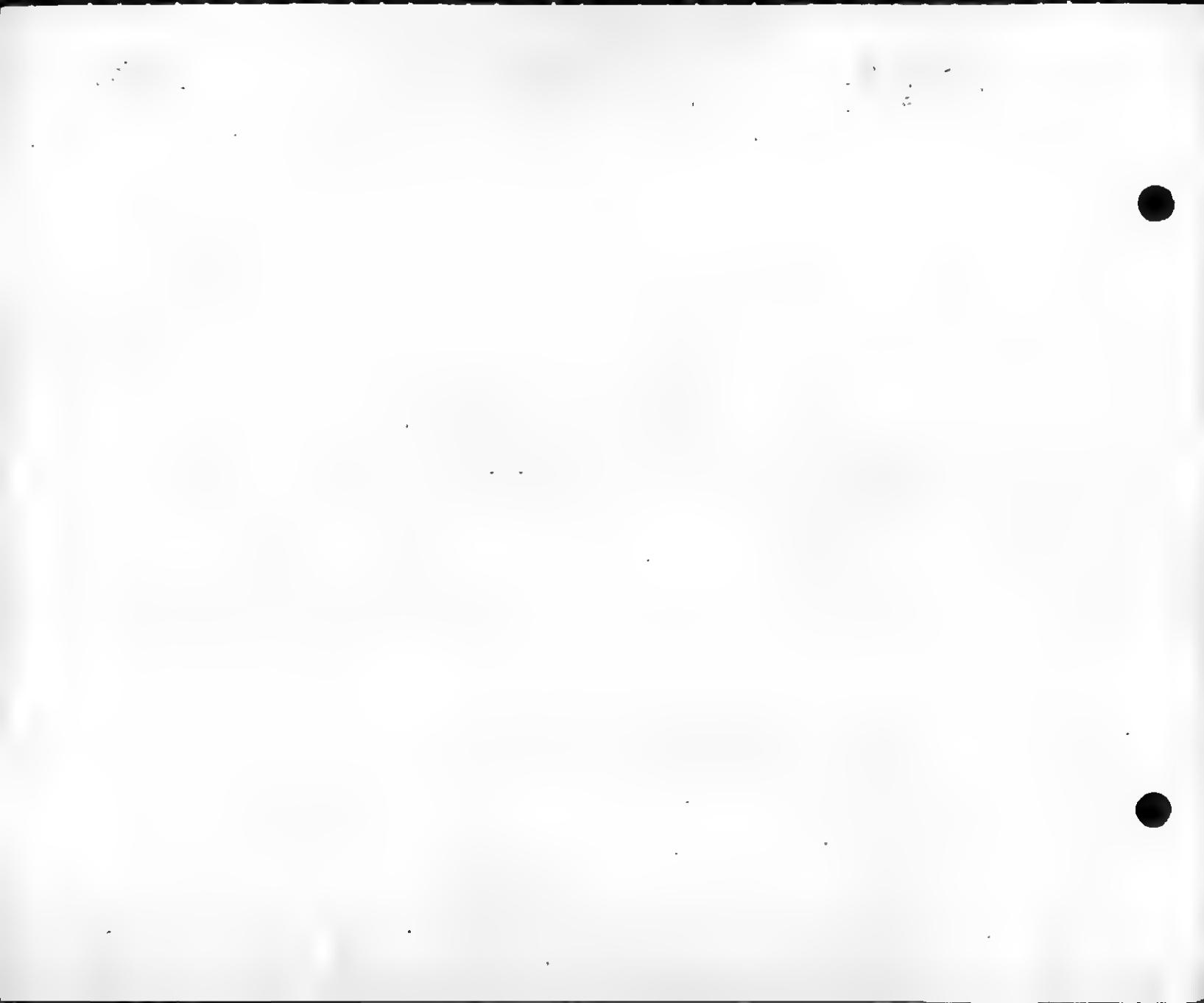
CERTIFICATE OF DEATH

14655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon paper. **Page 4** and **2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)																	
		a. STATE <u>Md.</u>		b. COUNTY <u>PRINCE GEORGE'S</u>															
		3115 Varmum St. Mt. Rainier, Md.																	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																	
		16.1																	
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>11561 1/2 16th St</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
13		<u>Leland Memorial Hospital</u>		<u>3408 Queensbury Rd Hyattts</u>															
3.		NAME OF DECEASED (Type or print)	First <u>James</u>	Middle <u>Frank</u>	Last <u>Thompson</u>	4. DATE OF DEATH <u>Oct. 10 1966</u>	Month	Day	Year	IF UNDER 1 YEAR <input type="checkbox"/> Months	IF UNDER 24 HRS <input type="checkbox"/> Days	Hours	Min.						
5.		SEX <u>Male</u>	COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1889</u>	9. AGE (In years last birthday) <u>77 yrs</u>													
10a.		KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13.		FATHER'S NAME <u>Daniel Webster Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J.F. Thompson Jr.</u>		Address <u>2443 Monroe St. NW</u>							
18.		CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																	
PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a) <u>Coronary/arteries</u> INTERVAL BETWEEN ONSET AND DEATH <u>months</u>																	
4.201		DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>coronary/arteries</u>		DUE TO <u>2 years</u>															
(c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1966</u> to <u>Oct 10, 1966</u> that (I) (we) last saw the deceased alive on <u>Oct 6, 1966</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.																			
22a. SIGNATURE <u>John J. Thompson</u>														22b. DATE SIGNED <u>Oct 13 1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>John J. Thompson</u>		22d. ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-66</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Fort Lincoln Cem.</u>		23d. LOCATION (City or Town) <u>Colmar Manor, Md.</u>		(County)		(State)									
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		ADDRESS <u>300 1/4th St. N.E. Wash.</u>		25a. RECD. BY REGISTRAR <u>OCT 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>													
VR A15 (4 20 M 1/68)																			



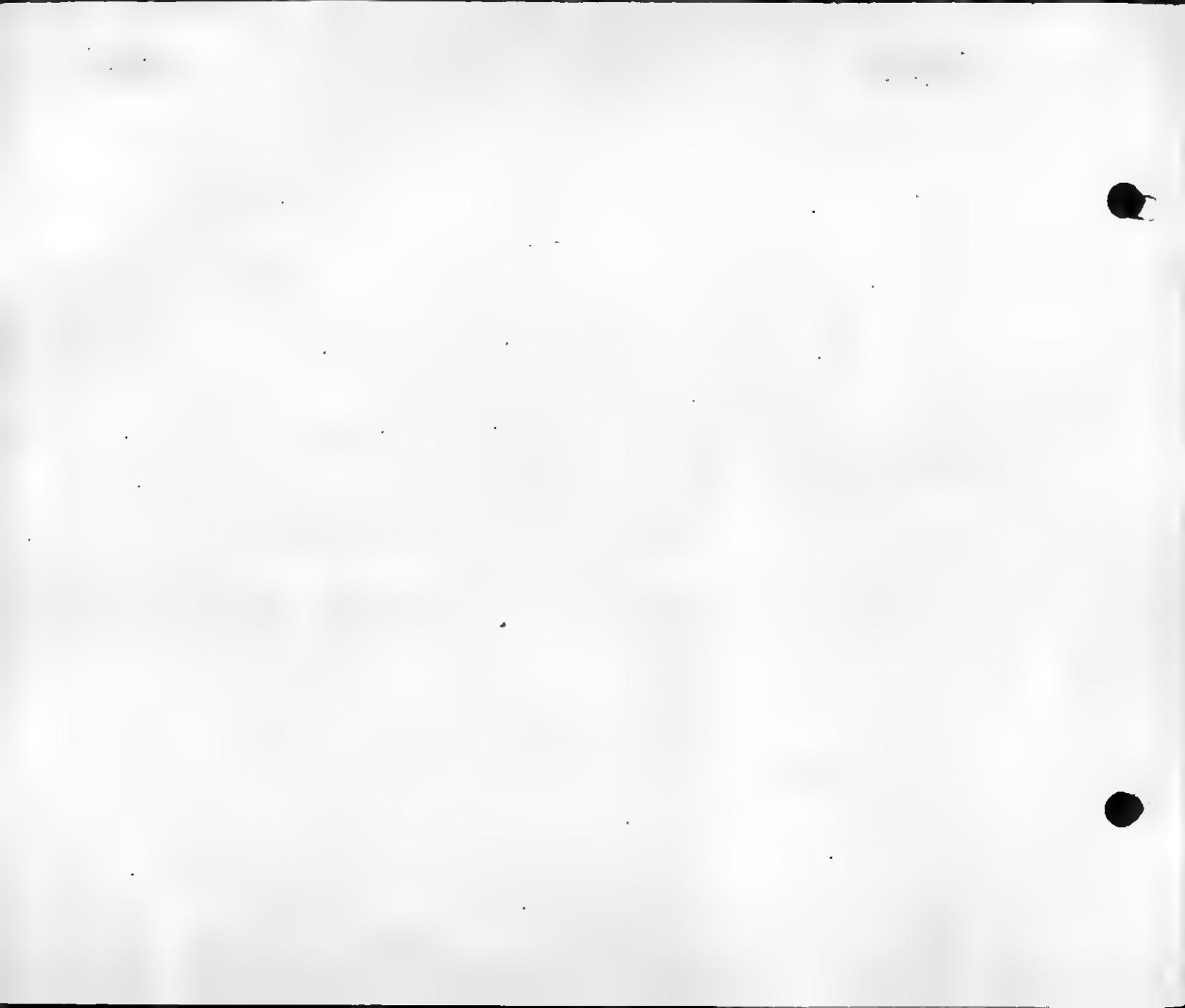
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14654

14656

1. PLACE OF DEATH a. COUNTY <i>Prince Georges, Maryland</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>cheverly, Md.</i>	c. LENGTH OF STAY IN 1b	b. COUNTY <i>Pr. Geo.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>carrollton.</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's General</i>		d. STREET ADDRESS <i>6433 Fairbanks St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Emily</i>	Middle <i></i>	Last <i>Todd</i>
4. DATE OF DEATH	Month <i>Oct.</i>	Month <i>11</i>	Day <i>11</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22 1888</i>
9. AGE (In years last birthday) <i>78 yrs.</i>		10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>ASHBURNHAM, MASS.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William DELANEY</i>	
14. MOTHER'S MAIDEN NAME <i>BRIDGET A. CARNEY</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO <i>028-22-5219</i>		17. INFORMANT <i>George W. Todd</i>	Address <i>3516 Bradley Lane, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		Coronary Thrombosis	
(b) DUE TO <i>Arteriosclerotic Heart Disease</i>		several years	
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 12, 1966</i> , to <i>Oct 11, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept 28, 1966</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>Oct 11, 1966</i>	
22c. SIGNATURE <i>W H Clements</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <i>6001-35th Ave, Hyattsville, MD 20782</i>
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct 14, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Bernard's Cemetery</i>
23d. LOCATION (City, town, or county) <i>Fitchburg Mass.</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>H. Don DeVol 222 W. 1st, Am. N.W.</i>		25a. ADDRESS <i>Wash. D.C.</i>	25b. REC'D BY REGISTRAR <i>OCT 17 1966</i>
25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14655

14657

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. LENGTH OF STAY IN 1b 8 mo. yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4012 Van Buren St Hyattsville		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
3. NAME OF DECEASED (Type or print) FRANK Michael		First FRANK	Middle Michael
4. DATE OF DEATH THROZZO		Last THROZZO	Month OCT Day 20 Year 1966
5. SEX MALE		6. COLOR OR RACE CAL	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 6, 1926		9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most at working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY General Practice	11. BIRTHPLACE (State or foreign country) Rillton, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK Michael THROZZO	
14. MOTHER'S MAIDEN NAME Ella Kaiser		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO. WV 11 175-29-6667		17. INFORMANT Eleanor M. Trozzo Address 4012 Van Buren Street Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colic, respiratory failure		INTERVAL BETWEEN ONSET AND DEATH Minutes	
2591 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO		9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) HEPATIC FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Attended the deceased from Jan 30, 1966 to Oct 20, 1966, that (I) (we) last saw the deceased alive on Oct 20, 1966, and that death occurred at 10 AM, from the causes and on the date stated above.	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3415 Hamilton St Hyattsville		20f. (City or town) Arlington, Virginia (County) Arlington (State) VA	
21. I certify that (I) (we) attended the deceased from Jan 30, 1966 to Oct 20, 1966, that (I) (we) last saw the deceased alive on Oct 20, 1966, and that death occurred at 10 AM, from the causes and on the date stated above.		22b. DATE SIGNED 10-20-66	
22a. SIGNATURE Paul A. DeVore		22b. DATE SIGNED 10-20-66	
22c. PHYSICIAN'S NAME (Type) Paul A. DeVore, MD		22d. ADDRESS 3415 Hamilton St Hyattsville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 24, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d. LOCATION (City, town, or county) Arlington, Virginia (State) VA	
24. FUNERAL DIRECTOR'S SIGNATURE Clark E. Wiggin ADDRESS Georgia Ave. Warren E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge DATE OCT 25 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
14656

CERTIFICATE OF DEATH

14658

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES		2 USUAL RESIDENCE (Where deceased lived, if institutional before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE		b. COUNTY PRINCE GEORGES	
c. LENGTH OF STAY IN b FORESTVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) REGENCY NURSING HOME, MARLBORO PIKE		d. STREET ADDRESS 5437 SPRING STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARLO VOLTA		First CARLO	Middle VOLTA
Last		4. DATE OF DEATH OCTOBER 31, 1966	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. B. DATE OF BIRTH Jan. 20, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY GROCER	9. AGE (In years last birthday) 82 yrs
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ARMAND J. VOLTA 3300 Roslyn Ave. District Hgt
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Congestive Heart Failure arterio Sclerotic Cardio Vascular Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5509 Silver Hill Rd, Suitland, Md
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Aug , 19 64 , to Oct , 19 66 , that (I) (we) last saw the deceased alive on 10-31 19 66 , and that death occurred at 11P M, from causes and on the date stated above.	
22a. SIGNATURE <i>John Folliay</i>		22b. DATE SIGNED 11-1-66	
22c. PHYSICIAN'S NAME (Type) <i>John Folliay</i>		22d. ADDRESS 5509 Silver Hill Rd, Suitland, Md	
23a. BURIAL, CREMATION, BURIAL/CREMATION (Specify) BURIAL		23b. DATE THEREOF NOV. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEMETERY
23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND		24. FUNERAL DIRECTOR ROBERT E WILHELM	
ADDRESS FUNERAL HOME 4308 SUITLAND ROAD		25a. REC'D BY REGISTRAR DATE NOV 4 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14657

CERTIFICATE OF DEATH

14659

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE

Maryland

b. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

2 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New Carrollton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

7611 Topton Street

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)First: Robert
Middle: H

Last: Wagenhouser

4. DATE
OF
DEATH
OctoberMonth: Day: 5
Year: 1966

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

9. AGE (In years
last birthday)

F. UNDER 1 YEAR

IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED

10. DATE OF BIRTH

Months: 76

Years: yrs

Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life preferred)

Ret. Auto Mechanic

10b. KIND OF BUSINESS OR
INDUSTRY

Self

11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania12. CITIZEN OF WHAT
COUNTRY?

U.S. A

13. FATHER'S NAME

James Wagenhouser

14. MOTHER'S M AIDEN NAME

Jennie Hosler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-20-1578

17. INFORMANT

Margaret E. Wagenhouser Same as #2

Address
INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Acute myocardial infarction

1043

DUE TO

Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost

Atherosclerotic heart disease

(b)

DUE TO

acute Leukemia, type undetermined

(c)

DUE TO

acute Hemorrhagic pulmonary edema.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb 1966 to Oct 6, 1966 that (I) (we) last
saw the deceased alive on Oct 6, 1966, and that death occurred at 2:30 P.M. from causes and on the date stated above.

22a. SIGNATURE

William D. Rosson, M.D.

22b. DATE SIGNED

Oct 17, 1966

22c. PHYSICIAN'S
NAME (Type)

William D. Rosson, M.D.

22d. ADDRESS

5701 85th Ave. Hyattsville, Md.

23a. BURIAL, CREMATION,
BENEFITS (Specify)23b. DATE THEREOF
10/8/6623c. NAME OF CEMETERY OR CREMATORY
Holy Trinity23d. LOCATION (City or Town)
Collington P.G.

(County) (State)

24. FUNERAL DIRECTOR

ADDRESS

Francis Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

OCT 10 1966

Charles Judge

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PL-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 1/2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14658

1. PLACE OF DEATH 2. COUNTY		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. FUNDER 1 YEAR		11. FUNDER 24 HRS			
Prince George's Maryland		Elna		Ward		Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-23-1908		58 yrs.		Months		Days		Hours	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN BD		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?															
Cheverly		1 month		7411 Hawkins Drive, Rt. 1		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?																	
Prince George General Hospital		7411 Hawkins Drive, Rt. 1		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First		Last		4. DATE OF DEATH		Month		Day		Year									
Elna				Ward		10		11		19		66									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. FUNDER 1 YEAR		11. FUNDER 24 HRS									
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-23-1908		58 yrs.		Months		Days		Hours							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?															
Housewife		Own Home		Pasadena, Md.		USA															
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Sarah Chard																	
Harry D. Cook		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address													
No						Earl Cook, Crownsville, Md.															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac arrhythmia with congestive heart failure		8164		DUE TO		Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		(b)		Rupture of spleen		INTERVAL BETWEEN ONSET AND DEATH					
								DUE TO				(c)		Trauma auto accident		4 weeks					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
		8-45pm p.m. 9-11- 1966		Rt. 301 at Queen Ann Rd., Upper Marlboro, Md.																	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		EXAMINER'S NAME (Type)		John Kehoe, M.D.		RIVERDALE, MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED							
		ACTUAL SIGNATURE		John Kehoe										10-11-66							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		66		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)											
Burial		14 October		Mt. Carmel Cemetery		ADDRESS		Lake Shore, Pasadena, Md.													
24. FUNERAL DIRECTOR		Kirkley Funeral Home, Glen Burnie, Md.		DATE		OCT 14 1966		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 1501 10/1/66 mh

14658

CERTIFICATE OF DEATH

14661

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)					
Prince George's Forestville MARYLAND		a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
c. LENGTH OF STAY IN 16		10/1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Suitland, Md.					
The Regent		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Robert	Middle Mae				
4. DATE OF DEATH 10/1/66		Month Oct	Day 19				
5. SEX F		6. COLOR OR RACE i.	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>	9. AGE (In years at birthday) 86 yrs.	10. IF UNDER 24 HRS. Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher William		14. MOTHER'S MAIDEN NAME Annie Carriso					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				Joseph Knott #18 Ky. Ave. Parkland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4201 Acute Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Atherosclerotic heart disease		1/2 hr.			
		DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from 10/6/66 to 10/7/66, that (I) (we) last saw the deceased alive on 10/6/66, and that death occurred at 8:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE WALTER B. SHAFER				22b. DATE SIGNED 10-7-66			
22c. PHYSICIAN'S NAME (Type) WALTER B. SHAFER		22d. ADDRESS 6400 Maryland Pike S.E. Forest Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Prince Georges Maryland	(County)	(State)	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. Suitland Md.				25a. RECD BY REGISTRAR OCT 11 1966	25b. REGISTRAR'S SIGNATURE Walter J.		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 303 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film 382117766 mm

14660

CERTIFICATE OF DEATH

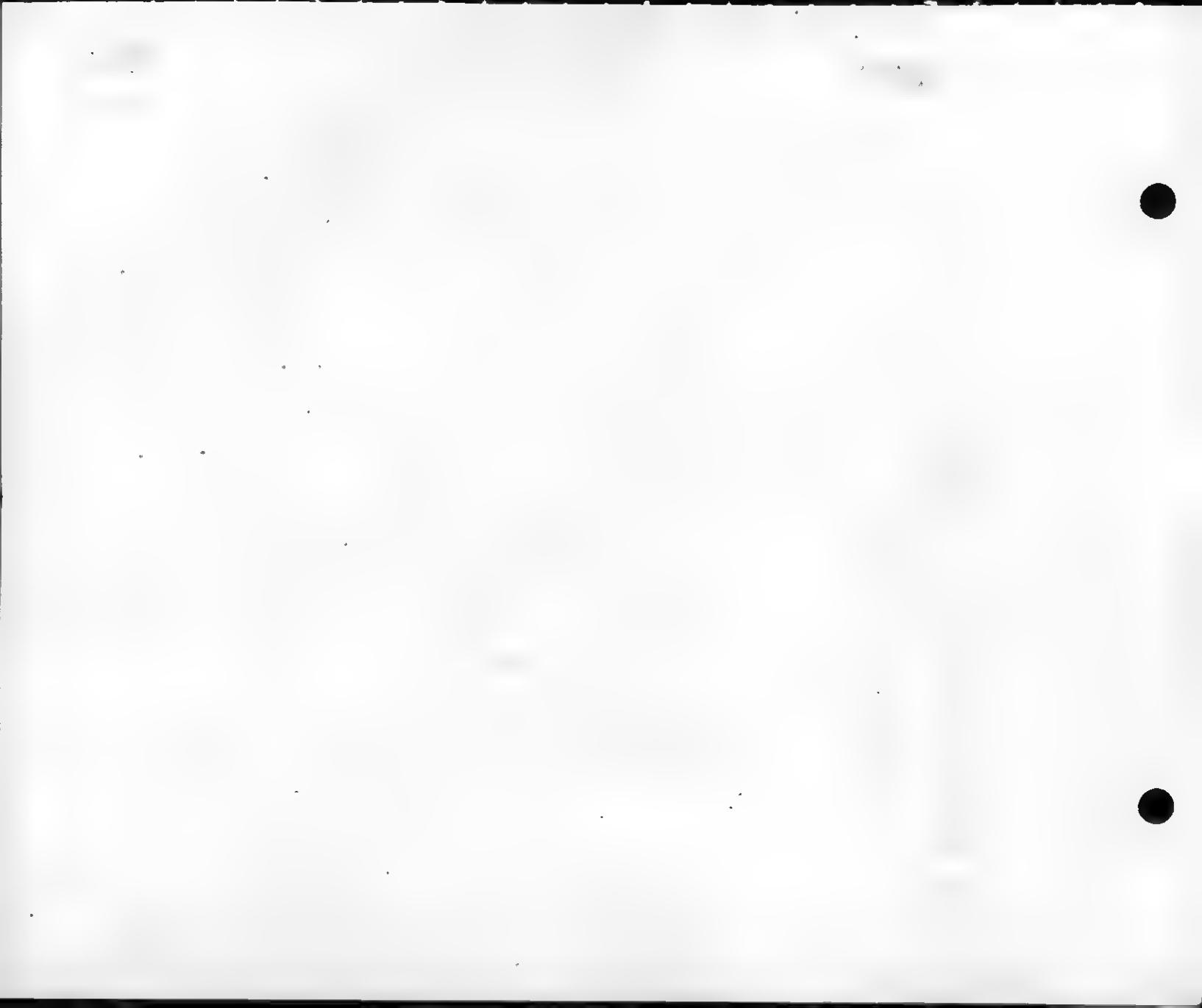
14663

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4305 Farragut st		d. STREET ADDRESS 4305 Farragut St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Bertha	Middle B	Last Weber
4 DATE OF DEATH	Month Oct	Day 26,	Year 19 66
5 SEX female	6 COLOR OR RACE white	7 MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8 DATE OF BIRTH May 22, 1886		9 AGE (In years last birthday) 80 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11 BIRTHPLACE (County & State or foreign country) Washington D. C.	
12 CITIZEN OF WHAT COUNTRY? U-S-A.			
13. FATHER'S NAME Fritz Walker		14. MOTHER'S MAIDEN NAME Bertha Shellhorn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Dolphin W Weber		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Coronary Occlusion Arteriosclerotic Heart Disease 10 years			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Influenza			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 1966 to Oct , 1966 that (I) (we) last saw the deceased alive on Oct 25 1966 and that death occurred at 9:30 AM from causes and on the date stated above.			
22a. SIGNATURE Leon L. Gallin M.D.		22b. DATE SIGNED 10/27/66	
22c. PHYSICIAN'S NAME (Type) Leon L. Gallin M.D.		22d. ADDRESS 7236 Adelphi Rd. N. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 29, 1966	
23c. NAME OF CEMETERY OR COLUMBIUM		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE OCT 31 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14661

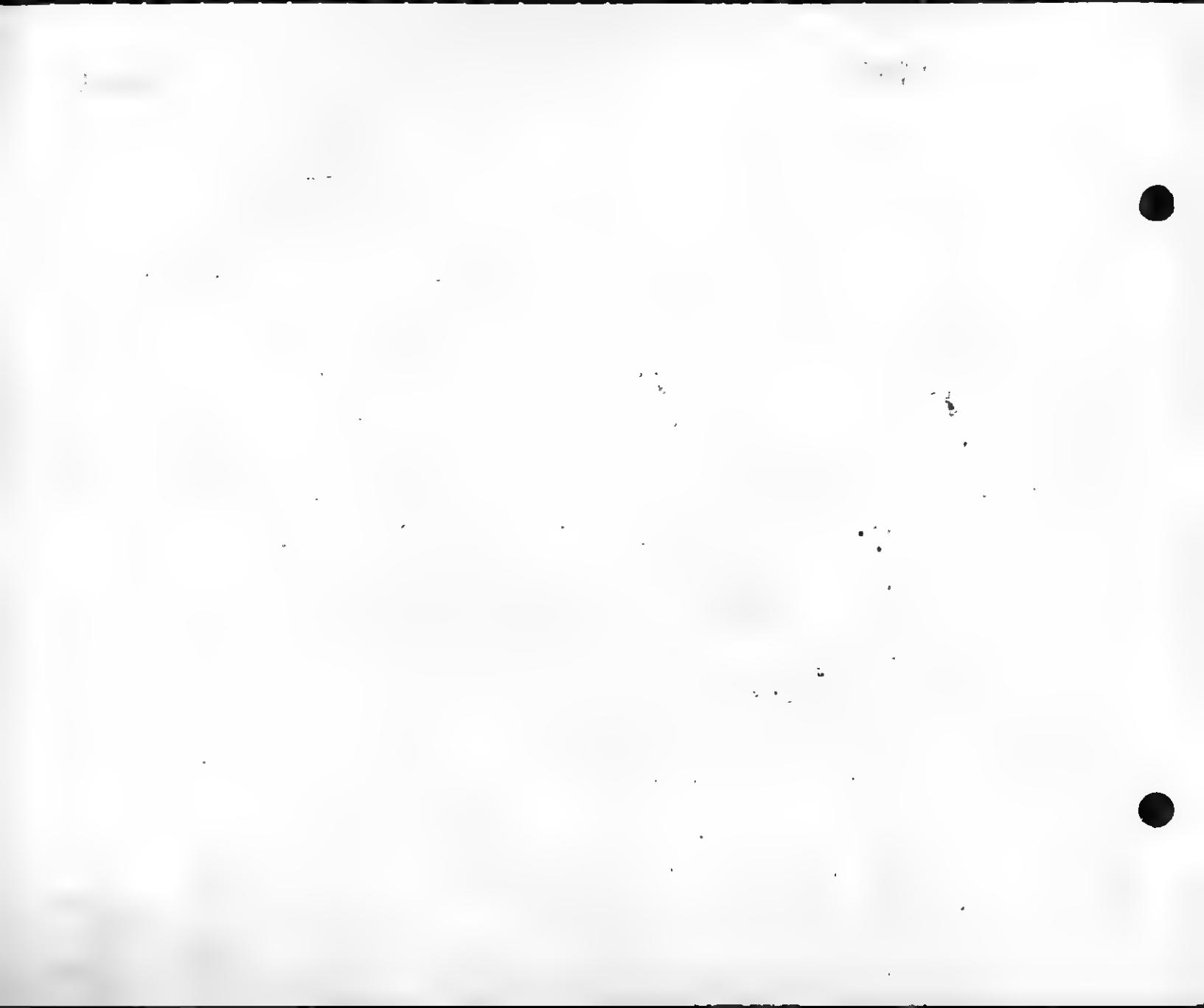
CERTIFICATE OF DEATH

14664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 11301 Mitscher St.	
3 NAME OF DECEASED (Type or print) First Alice Middle J Last Wessel		4. DATE OF DEATH Oct., 29 1966	
5 SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED	
9. DATE OF BIRTH 23 June 1888		10. AGE (In years last birthday) 78 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter C McCloskey		14. MOTHER'S MAIDEN NAME Mary J. Whalen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John J. Wessel 11301 Mitscher St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cerebral Thrombosis stated. DUE TO (c) Ascvd years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/25, 1966, to 10/29, 1966, that (I) (we) last saw the deceased alive on 10/29, 1966, and that death occurred at 3:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE Paul A DeVore		22b. DATE SIGNED 10-30-66	
22c. PHYSICIAN'S NAME (Type) PAUL A DEVORE, MD		22d. ADDRESS 3415 Hamilton St Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-3-66.		23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven	
23d. LOCATION (City or Town) Chester MD		(County) (State)	
24. FUNERAL DIRECTOR Hanson Funeral Home		25a. ADDRESS Washington D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 3 1966	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14662

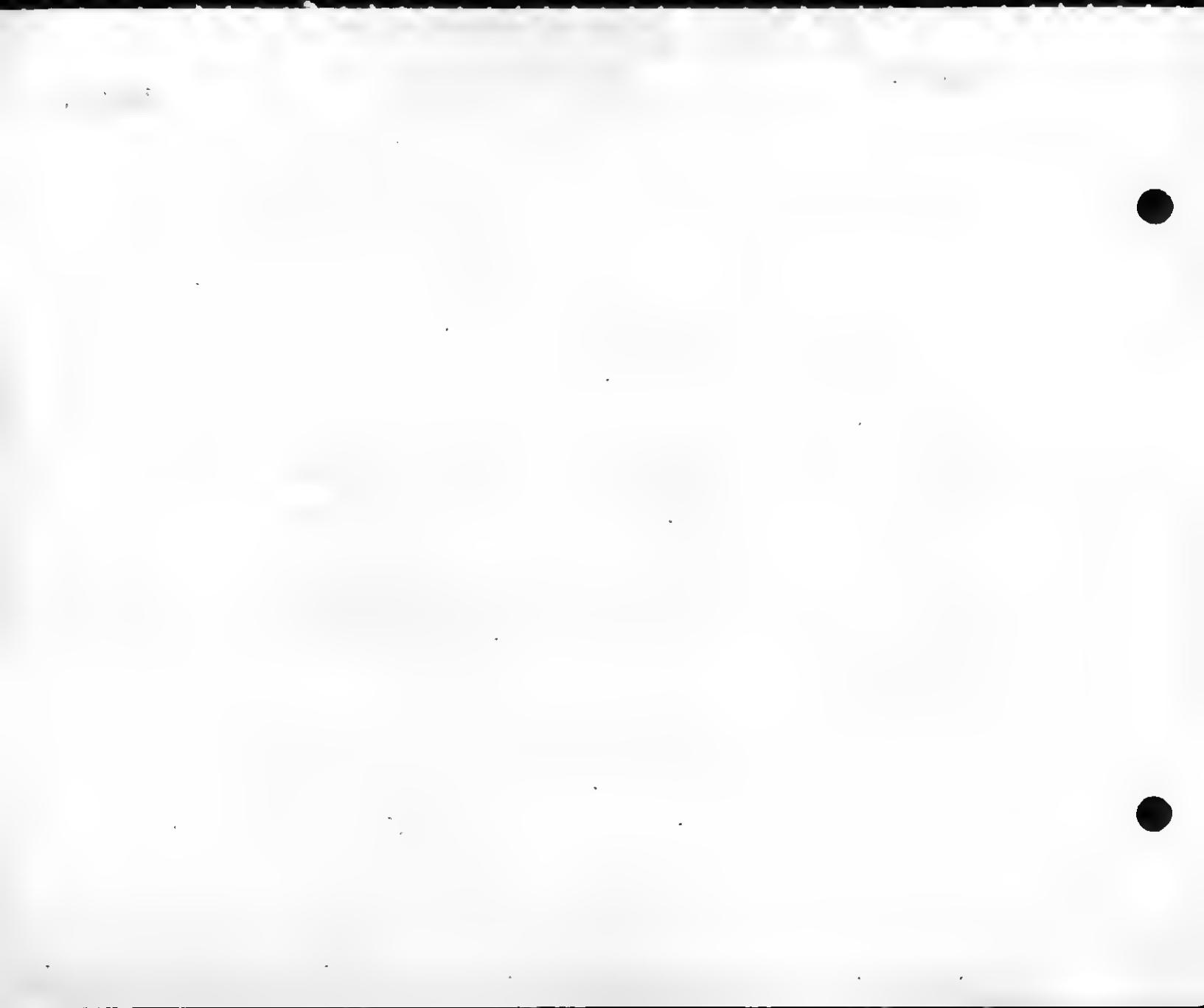
CERTIFICATE OF DEATH

14665

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Reside before admission) a. STATE D. C. b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 4 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First: May Middle: Whittaker Last: Whittaker		4. DATE OF DEATH Oct. 24 1966	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	
13. FATHER'S NAME Isaac C. Whittaker		11. DATE OF BIRTH Dec. 7, 1878	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal bronchopneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) CVA (Thrombosis) Left Lempylegia DUE TO c) Advanced severe arteriosclerosis		19. INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Senility and senile dementia	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 10/25/66 to Oct 24, 1966, that (1) (we) last saw the deceased alive on 10/22/66, and that death occurred at (2) (a) M, from causes and on the date stated above			
22a. SIGNATURE Herbert S. Gates		22b. DATE SIGNED 10.24-66	
22c. PHYSICIAN'S NAME (Type) HERBERT S. GATES		22d. ADDRESS 819-EAST CAPITOL ST. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR J. Wm. Lees Sons		25a. RECD BY REGISTRAR DATE OCT 26 1966	
		25b. REGISTRAR'S SIGNATURE Charles J. ...	



14663
14666
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE							
Prince George's MARYLAND				Maryland							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 28 days							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Riverdale 161							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Charles			N.	Winters	Winters	October	8	19	66		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)	10. IF UNDER 1 YEAR 11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2/19/83		83 yrs.	Months Days Hours Min.	U. S. A.	Charles N. Winters		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman			10b. KIND OF BUSINESS OR INDUSTRY Real Estate			11. MOTHER'S MAIDEN NAME Emma Robinson			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.			17. INFORMANT Florence M. Winters			Address Same as # 2 (Wife)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of rectum</u> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Escrector 10-4-66</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED p.m. 19 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>9-1, 1966</u> to <u>10-8, 1966</u> , that (I) (we) last saw the deceased alive on <u>10-8-1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			22b. DATE SIGNED <u>10-8-66</u>								
22c. SIGNATURE <u>George J. Hageage</u>			22d. ADDRESS 3717 38th Ave., Cottage City, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/10/66			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Colmar Manor Maryland		
24. FUNERAL DIRECTOR F. Gasch's Sons			ADDRESS Hyattsville, Maryland			25a. REC'D BY REGISTRAR DATE OCT 11 1966			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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14664

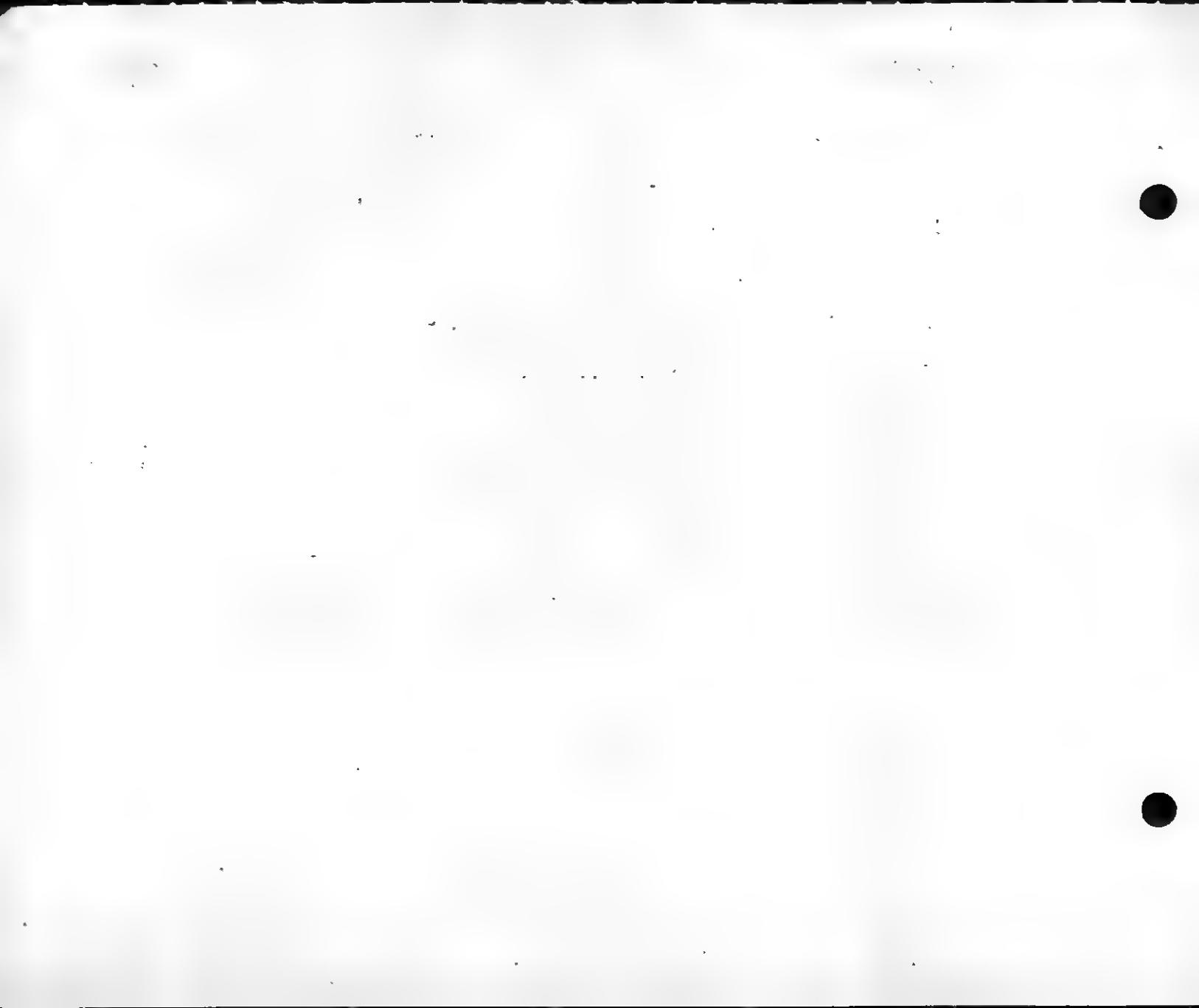
CERTIFICATE OF DEATH

14667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Prince George's			2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			b. COUNTY Prince George's		
c. LENGTH OF STAY IN 1b 10 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 6107 62nd Place		
3. NAME OF DECEASED (Type or print) Charles Harry Wolfe			First Charles	Middle Harry	Last Wolfe
4. DATE OF DEATH October 19 1966	Month October	Day 19	Year 1966	5. SEX Male	6. COLOR OR RACE White
7. MARRIED Married	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1900	9. AGE (In years lost birthday) 66 yrs
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Aid		10b. KIND OF BUSINESS OR INDUSTRY Wash. Sub. San.		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME John Harry Wolfe			14. MOTHER'S MAIDEN NAME Marguerite Massey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 218 20 1550A		
17. INFORMANT Catherine G. Wolfe			Address E Riverdale, Md.		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Thromboses of rt coronary artery OUE TO stating the underlying cause (c) arteriosclerosis heart disease INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) pulmonary embolism, embolism					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Oct 19 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Colmar	(County) Manor
21. I certify that (I) (this hospital) attended the deceased from Oct 9, 1966 to Oct 19, 1966 that (I) (we) last saw the deceased alive on Oct 19, 1966 and that death occurred at 2:15 PM , from causes and on the date stated above.					
22a. SIGNATURE Don B. Cameron		M.O. ATTENDING PHYS. Don B. Cameron	M.D. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Oct 20, 1966
22c. PHYSICIAN'S NAME (Type) Don B. Cameron		22d. ADDRESS 3503 PERRY ST. TOWSON			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 22, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery	23d. LOCATION (City or Town) Colmar Manor Pro Geo	(County) Manor
24. FUNERAL DIRECTOR F. Jasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14665

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

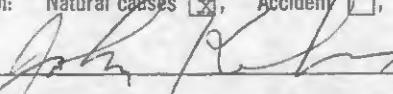
VR A15 (4)
15M 4-64

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		c. LENGTH OF STAY IN 1b <i>2 yr</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Paint Branch Nursing Home</i>		d. STREET ADDRESS <i>7403 Buchanan St.</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mrs. Catherine Elizabeth Wood</i>	First <i>Mrs.</i>	Middle <i>Catherine</i>	Last <i>Elizabeth</i>	
4. DATE OF DEATH <i>Nov 16 1881</i>	Month <i>Nov</i>	Day <i>16</i>	Year <i>1881</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>84 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Wash D.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John O'Neill</i>	14. MOTHER'S MAIDEN NAME <i>Georgina Whitney</i>	Address <i>Nursing Home Records</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. — — —	17. INFORMANT — — —	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1914</i> (b) <i>Mesothelioma to neck glands</i> DUE TO (c) <i>Carcinoma of skin of neck</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>While at work</i>	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 16, 1963</i> , to <i>Sept 28, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept 28, 1966</i> , and that death occurred at <i>10:15 AM</i> , from the causes and on the date stated above.				
22a. SIGNATURE <i>R. D. Bauer, M.D.</i>		22b. DATE SIGNED <i>Oct 5, 1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>R. D. Bauer, M.D.</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>2513 Bucklonge Rd. Hyattsville, Md.</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Oct 5, 1966</i>	23c. NAME OF CEMETERY OR BURIAL GROUND <i>Cedar Hill Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Suitland Pro Geo Md.</i>	
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>	ADDRESS <i>Hyattsville, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE	
DATE <i>OCT 5 1966</i>				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in my ^{agent} within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												MEDICAL EXAMINER'S CERTIFICATE OF DEATH												14670																	
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						b. COUNTY																													
Prince George's MARYLAND						Maryland						Prince George's																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																													
Riverdale						DOA						Adelphi																													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS						e. IS RESIDENCE ON A FARM?																													
Chamber's Funeral Home						2200 Phelps Rd., Apt. H1						16-1						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year	10			10			19 66																							
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)			10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS	12. CITIZEN OF WHAT COUNTRY?	54 yrs.			Months Days Hours Min.			U.S.																							
Male			White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	26 June 1912	11. BIRTHPLACE (State or foreign country)			PENNA.																																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						12. CITIZEN OF WHAT COUNTRY?																													
TROUBLE SHOOTER						FAIR LANE CORP						U.S.																													
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						FRANCES LESKO																													
JOHN ZEMERLIN						FRANCES LESKO						ADAH PENNA.																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES W.W. II						16. SOCIAL SECURITY NO.						17. INFORMANT						Address																							
UNKNOWN						MRS FRANCES PASCIA						ADAH PENNA.																													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH minutes																													
PART I. DEATH WAS CAUSED BY:												unknown																													
IMMEDIATE CAUSE (a) Heart failure																																									
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																																									
DUE TO Arteriosclerotic heart disease																																									
(c)																																									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED?																													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)											
Hour a.m. p.m. 19						White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>																																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>																													
ACTUAL SIGNATURE 												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												22. DATE SIGNED 10-11-66																	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
Address (Street, city, town, or county)												23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL												23b. DATE THEREOF Oct 14, 1966						23c. NAME OF CEMETERY OR CREMATORIAL MASON TOWN, PENN.						23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR												ADDRESS W.W. Chambers Co. Riverdale, Md.												25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE Charles Judge											
DATE OCT 14 1966																																									

